Communication and Resolution Programs: An Emerging Best Practice for Addressing Patient Harm

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Today’s Speakers

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Disclosures

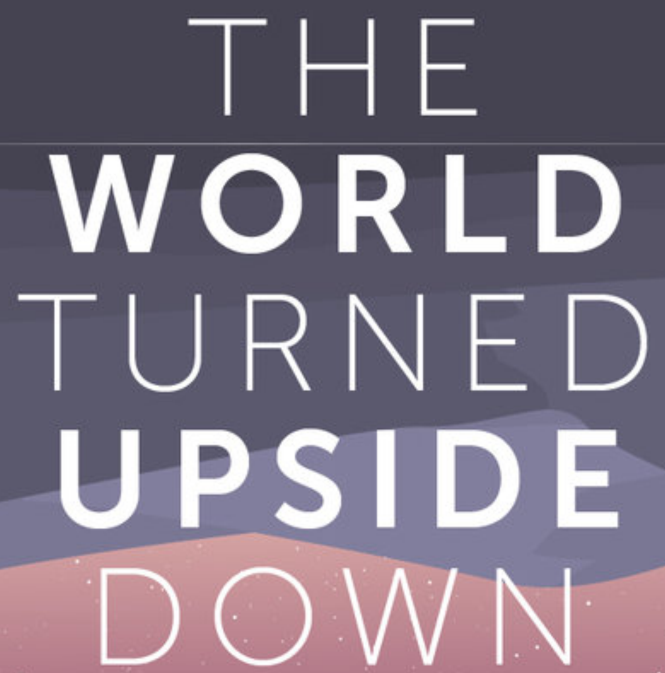
- Carole, Evan, and Tom have no conflicts of interest to disclose
- Richard runs a consulting business that helps organizations implement CRPs

Learning Objectives

1. Understand the critical role that CRPs play in reducing suffering of patients, families, and clinicians after harm events
2. List the core elements in the CRP process and why each of them matter
3. Describe 3 keys to successful CRP implementation and 3 obstacles to avoid
4. Articulate the ROI of a highly reliable CRP process

Today's Agenda

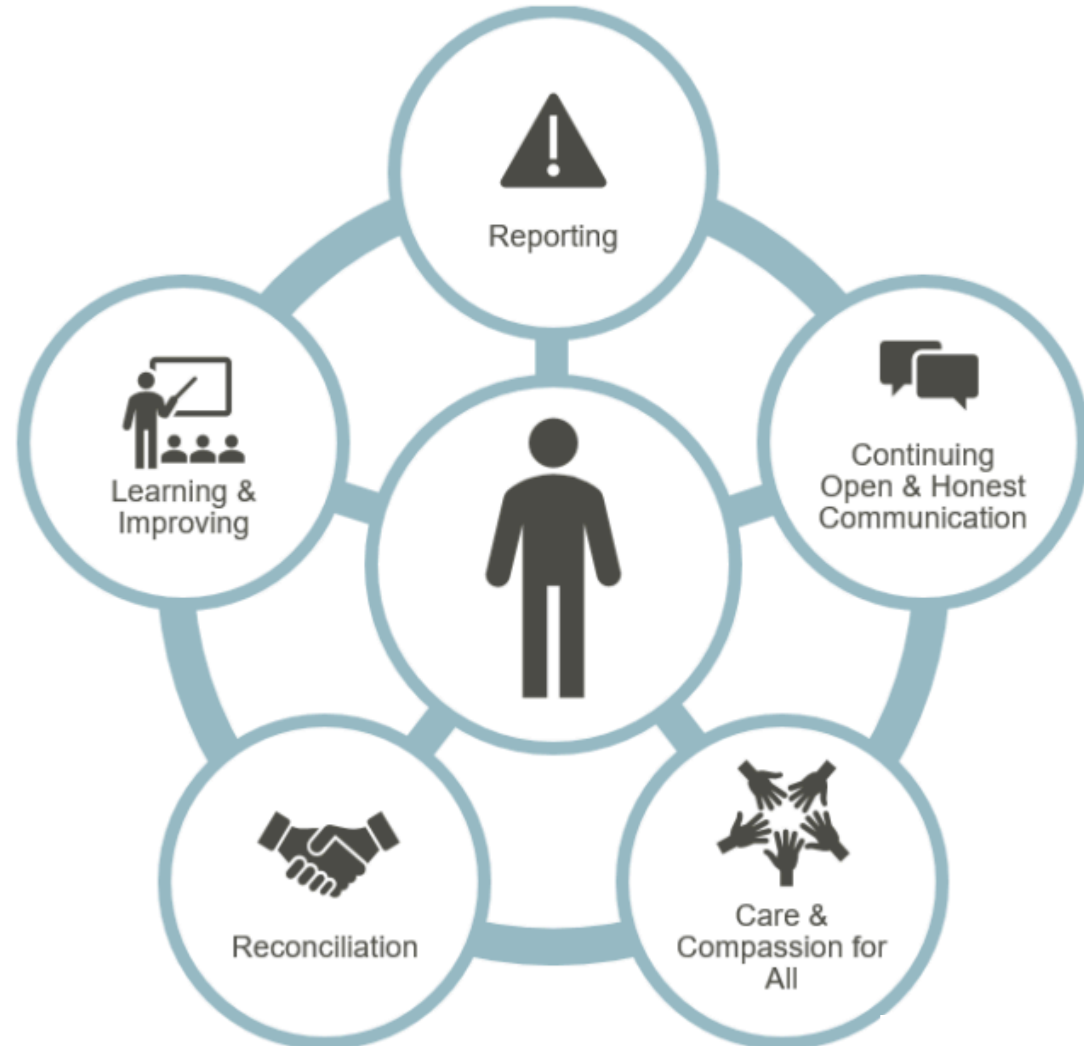
1. Why CRPs matter
2. How CRPs are a different approach to patient harm
3. The current state of CRPs
4. Steps in the CRP Process
5. Implementation strategies and lessons learned
6. Panel discussion and audience Q&A


THE
WORLD
TURNED
UPSIDE
DOWN

silence

Communication & Resolution Programs

- Principled
- Comprehensive
- Systematic
- Compassionate



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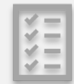
Patients/Families Want to Know

Tell us what happened



Take accountability

I’m Sorry

Tell us how you are going to fix the problem

Let us be part of the solution

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Connection

Heart

Head

Gut

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CRPs
What are they?
How are they Different?

"Communication & Resolution": An Unfortunate Label

- Erroneously implies that a CRP is ***primarily*** a claims settlement device
- Suggests that there IS "**resolution**" for patients harmed by medical error and their families
- To truly understand the intent behind a CRP, you must shift the primary focus AWAY from claims to nurturing a culture of ***clinical accountability***

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A Big Difference!

Organizations focused on claims ask, “Is this case defensible?”

In a true CRP, organizations ask, “Did the patient’s care meet our expectations (the standard of care)?”

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Claims-Oriented Organizations

- Organizations focused on claims often apply artificial restrictions:
  - We will not approach injured patients ***before*** they have asserted a claim
  - We would never offer compensation before patients have filed suit
  - We will snub any patient who has a lawyer
- Some contrive extreme restrictions to avoid even ***SEEING*** these patients
  - "We don't even count cases if the complication was actually listed on the consent form the patient signed."
- Claims-oriented organizations defer to "litigation thinking" and courts to respond
- Persistent, draconian thinking and practices continue to drive responses to patients harmed in their care:

  "Are you suggesting that we alleviate the mother's pain? It's her pain that will drive her to the negotiating table. It's her pain that will let us settle this case. We would never do THAT!"

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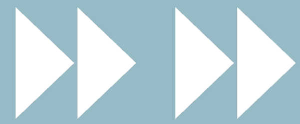
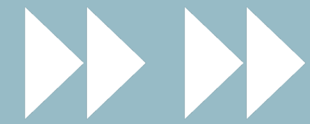
(A client's response to a strong recommendation that they offer interim help to the parents of a brain injured child before final settlement negotiations could begin)



The key difference is the driving motivation



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CRP Essential Operational Elements

CRP is aimed at a larger goal than simply early claims resolution: cultural accountability to drive continual improvement

Notification of unintended clinical outcome	Stabilize the clinical environment, protect other patients and staff	Support the patient, listen, promise full disclosure
Support the caregiver, listen, promise full disclosure	Normalize honesty, rigorous investigation and review, reach clinical conclusions	Share facts conclusions openly with caregivers and patients alike, then widely
Be principled and accountable. Compensate where warranted, be consistent in peer review	Leverage lessons learned in safety, quality and peer review in continuous quality and safety improvement	Measure improvement, communication, normalized, consistent, transparent and relentless

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CRP Essential Elements – Key Takeaways

1. Normalize clinical honesty as a reflex, a normal expectation of all involved in the clinical mission
2. See defensiveness as counterproductive to advancing the clinical mission
3. Act consistently, patient-by-patient every time

Current State of CRP

CRP Successes and Challenges

- Over 400 healthcare organizations and liability insurers have adopted (or are adopting) a CRP
- Spread of CRP to new care environments
- Evolution of tools to support implementation fidelity and promote quality improvement
  - Emerging interest in software integration
  - Growing CRP Learning Communities
- State laws in MA, OR, CO, IA
- Important opportunities exist to address policy barriers, maximize incentives

The Challenge of Inconsistent Implementation

- Use of CRP for some cases but not others
- Use of some but not all CRP elements for individual case
- Fuels skeptics' concern that CRPs are actually a claims management strategy
  - Raises doubt about commitment to transparency and safety culture, evasion of National Practitioner Data Bank/state medical board reporting

Ultimately, fewer patients, families, clinicians, and organizations benefit from CRP process

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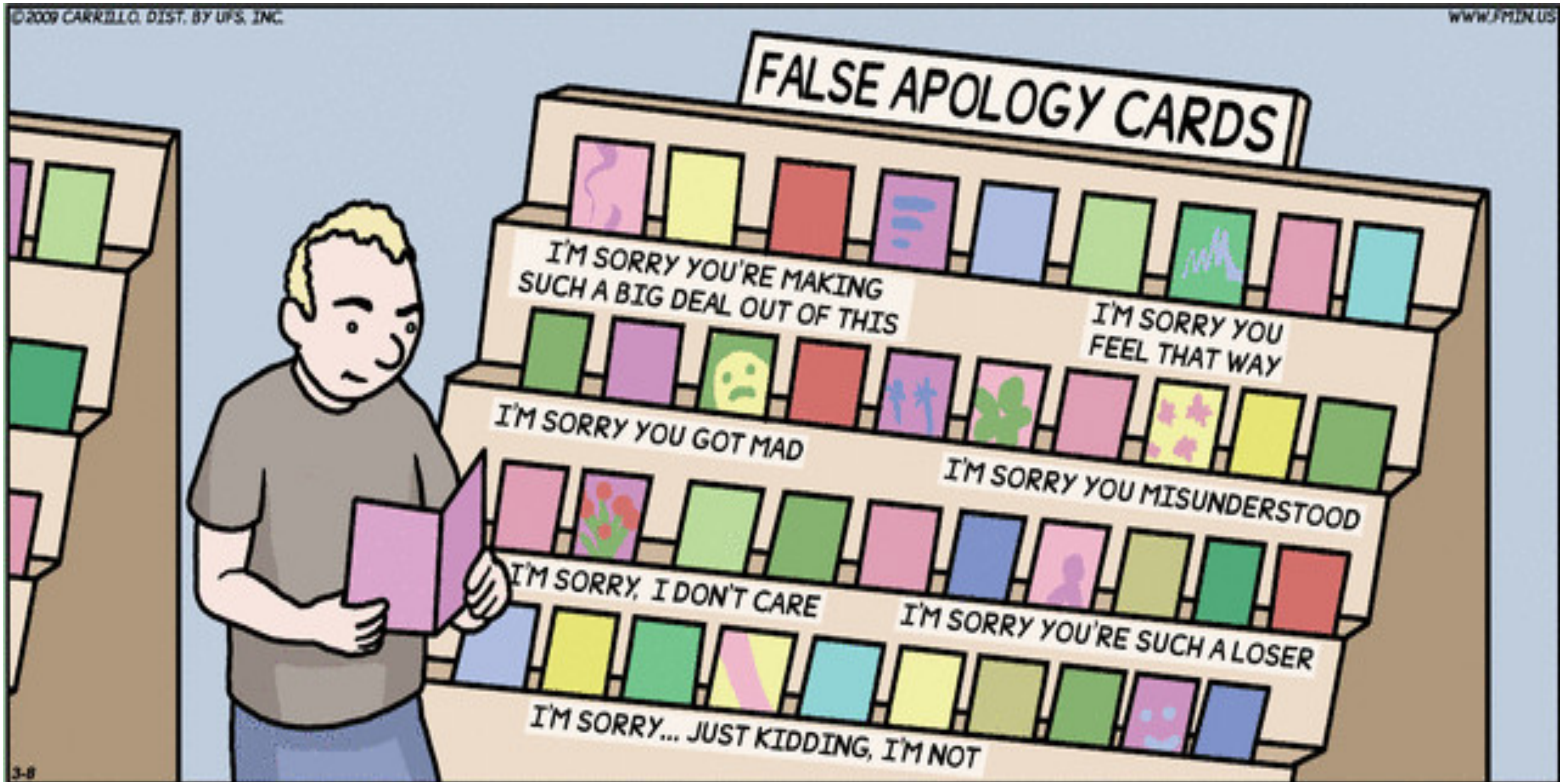

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Steps in the CRP Process

Culture, Event Reporting, and Event Analysis

Culture

Culture: "*The single greatest impediment to error prevention is that we punish people for making mistakes.*" Lucian Leape

- Leaders set norms and expectations that exemplify a culture of safety:
  - Psychological safety
  - Transparency
  - Organizational and continuous learning
  - Knowledge sharing
  - Just culture
  - These together are a "reporting culture"

Notification of Unintended Clinical Outcomes

- Does not wait for a claim
- Captures all unintended clinical outcomes regardless of suspected malpractice
- Driven by realization that “if it happened to one, it could happen to others
- Focus is on patients, not potential financial loss

Event Reporting

Culture of reporting exists as a foundation

The identification and reporting of a harm event initiates the CRP process and is a key foundational element of the CRP

The goal for an organization implementing the CRP is to increase the reporting of patient harm events

Staff training for reporting

When a patient harm event occurs, rapid and timely reporting and comprehensive documentation of the details of the event are imperative

Process to manage anonymous reporting exists

Key Elements of an Event Reporting System

- Supporting a rapid response to harm events
- Engaging all staff and providers as soon as possible following the event to secure their take on the event
- Engaging patients and family members as soon as possible
- Allowing immediate, anonymous, and confidential reporting and input from frontline staff and providers
- Protecting the organization to ensure the event analysis is not discoverable during a potential lawsuit
- Providing feedback to those who reported the event to help staff feel part of the process and the solutions

Event Analysis: Goal is Prevention

Within the first 72 hours of a harm event:

- Schedule and complete interviews with involved staff
- Review all records
- Notify liability insurance carrier(s)

Within 30-45 business days after the event:

- The investigation should allow for the determination of causal factors and violations of standard of care

Event Analysis

- Systems orientation – not individual blame
- Root Cause analysis:
  - System drivers of the event
  - Violation of standard of care
  - Harm as a result of the violation
- Consensus recommendations on causes, preventive action solutions, and violation of standard of care

Communication with Patients and Families

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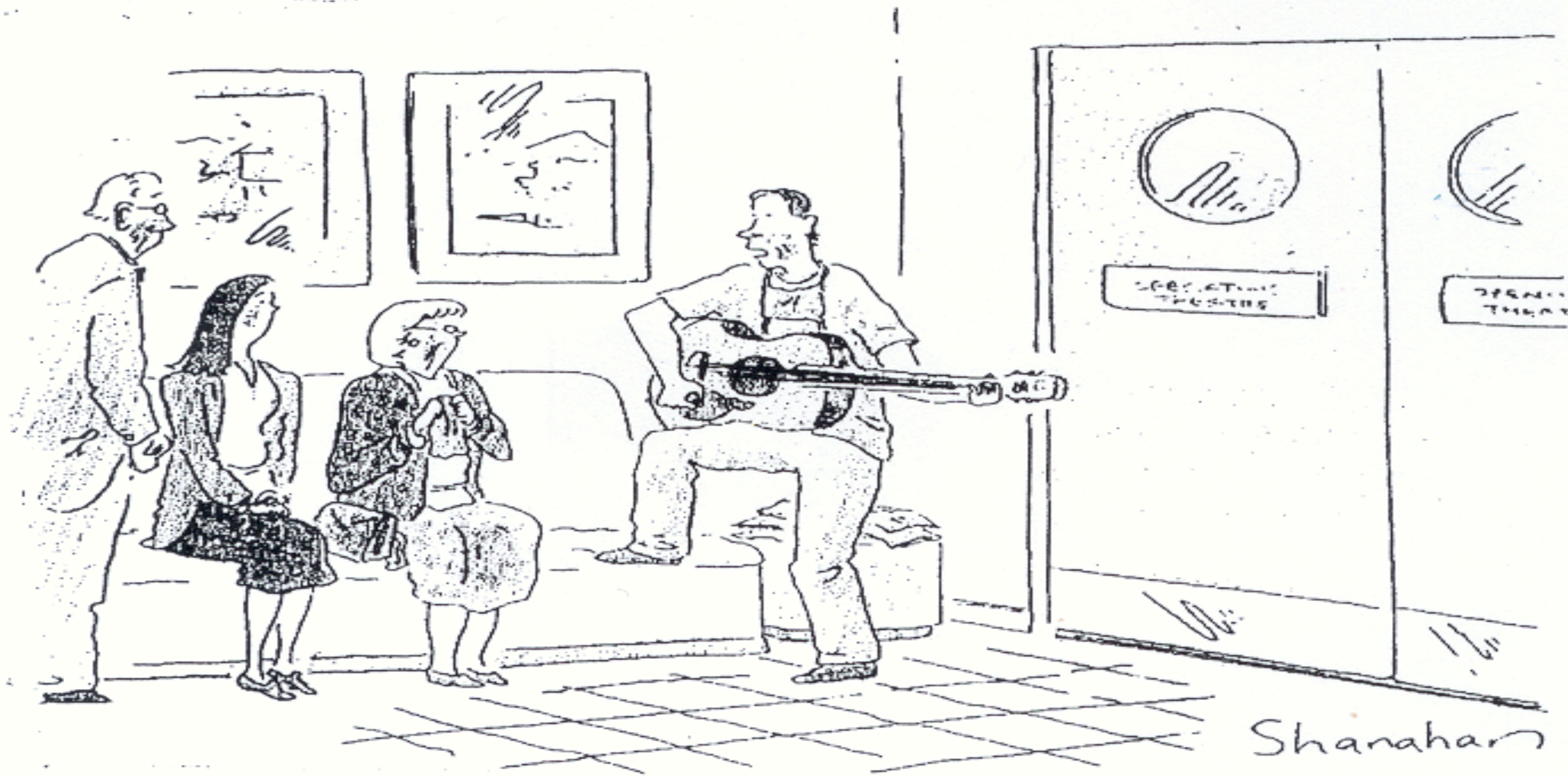

"Listen up, my fine people, and I'll sing you a song 'bout a brave neurosurgeon who done something wrong."

How We Communicate After Harm Events Matters

- We all have natural reflexes that can support and inhibit effective responses to patients and families after harm
  - Helpful-desire to share information, comfort patient/family, apologize, prevent event from happening again
  - Less helpful-urge to keep information to yourself, rationalize, minimize, blame
- Patients and families also have reflexive reactions
- Our fundamental obligation as healthcare workers is to respond to harm events in ways that support patients and families rather than traumatize them further

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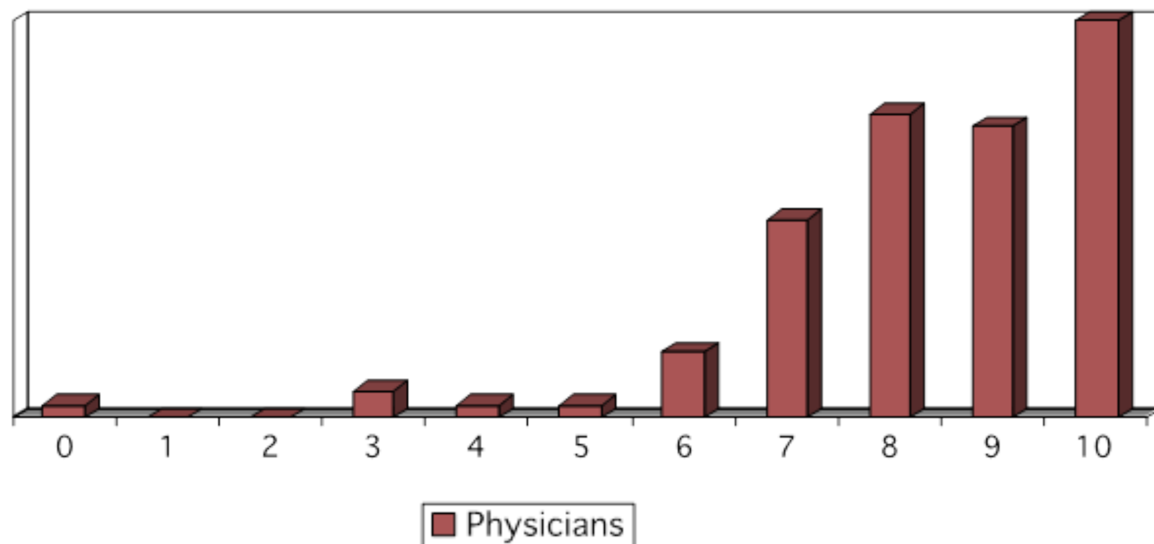
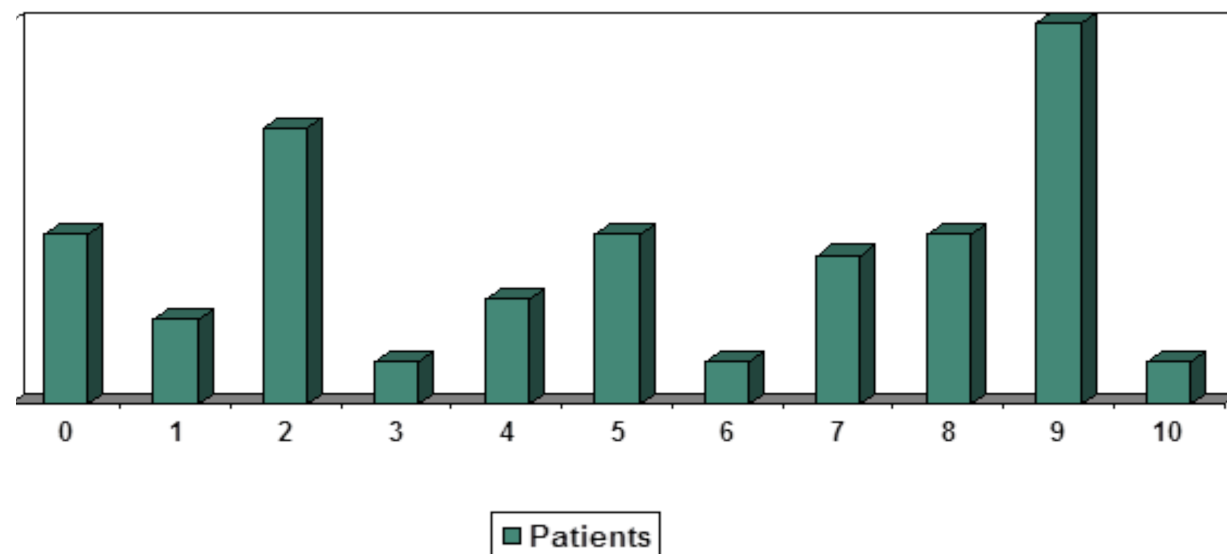
Quality of Actual Conversations about Harm Events With Patients?

- COPIC's 3Rs: Disclosure and Compensation Program
- 2007 – 2009
  - 837 harm events
  - 445 patient surveys
  - 705 physician surveys

Patient and Physician Rating of Quality of Harm Conversation





Ratings of quality of harm conversation on 0 (extremely low quality) to 10 (extremely high quality) scale

The Importance of Training Frontline Clinicians in Harm Communication

- The off-handed comments clinicians make to patients and families during and immediately after a harm event can set the stage for all that follows
  - (Immediately after patient falls) ***"I've told them the lighting by the bathroom door is too dim."***
  - ***"I've paged the doctor again-hopefully we'll hear back soon."***
  - ***"I wish they had called me sooner."***

Regaining trust with a patient and family if the initial harm discussion goes poorly is extremely difficult

Real and Imagined Barriers to Open Communication

- Fear of litigation
- Misunderstanding of patient preferences
  - Does not know/would not want to know
  - It would harm patient to know
- Low confidence in communication skills
- Mixed messages from institution
- Specialty-specific challenges
  - Radiology, pathology, birth injury, delayed diagnosis
- Shame/embarrassment

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

Biggest Mistake When Discussing Harm Events with Patients is…

Lack of planning and preparation for discussion

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Initial Harm Conversation: Do’s and Don’ts

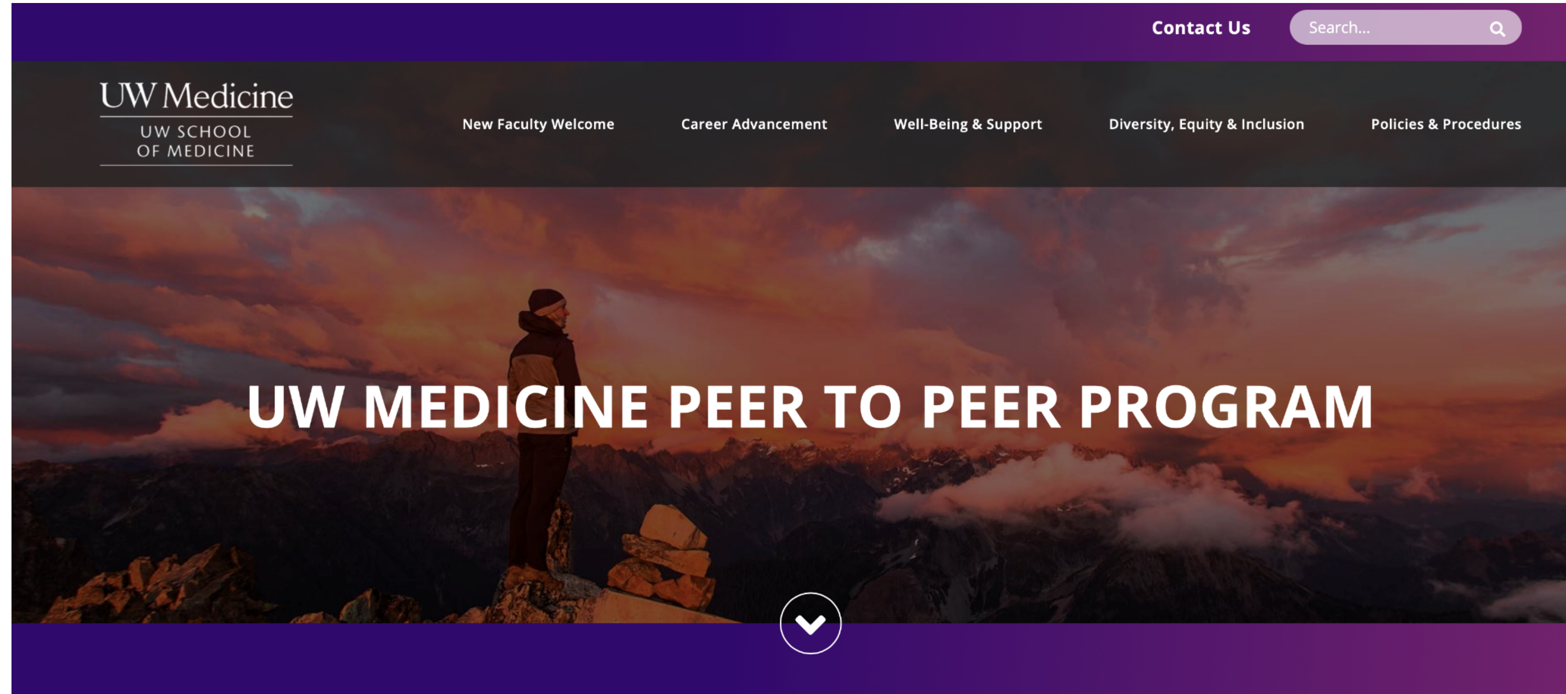
Do	Don’t
Acknowledge something unexpected has happened	Suggest that what happened was due to an error
Share facts about what is known	Speculate, even when pressed
Express empathy-verbally acknowledge and validate patient and family emotion	Ignore emotional cues, encourage patient to focus on the positive, or problem solve the emotion
Focus on patient and family perspective on what happened	Dominate the discussion with scientific/clinical explanation
Provide an expression of sympathy or regret for any unanticipated outcome	Provide a fault-admitting apology unless authorized to do so
Describe process that will follow	Make commitments about compensation

Care for the Caregiver

What Does the Provider Feel?

- Fear
- Self-doubt
- Disappointment
- Shame
- Isolation

Care for the Caregivers



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Resolution

“Apologizing for harm caused by avoidable medical errors without offering restitution is like showering in a raincoat: the apology may help you feel all warm inside but at the end of the day you’re still dirty.”

-Lucian Leape

CRP Resolution

"Resolution" in this context is resolution of a potential claim with or without financial compensation

There is almost never true "resolution" for the patient, family injured by preventable harm

CRP Resolution

- Patients harmed mostly want three things:
  - Acknowledgement of the harm
  - Accountability
  - Reassurance other patients will not be similarly harmed
- Honesty is critical and not all unintended clinical outcomes deserve compensation
  - Resolution includes full explanations without compensation where warranted
- Every patient who suffers harm in an unintended clinical outcome is minimally entitled to:
  - Compassion
  - Be heard
  - Best clinical efforts in a continuation of the patient-caregiver relationship, and
  - A full and honest explanation

CRP Resolution for Harm Caused by Care Deemed Unreasonable

- Because achieving and reinforcing clinical accountability is a key goal of a CRP:
  - Isolating the harm caused through “unreasonable care” becomes important
  - Art, not a science
  - Litigation is ever present as an alternative and impacts somewhat the approach
  - Cannot entirely shed the “market value” approach to claims, but it is desirable to be as evidence-based as possible when attempting to offer financial compensation for harm
  - Indispensable:
    - Medical experts necessary to isolate the harm, outline future injuries
    - Life care planner
    - Health care economist
    - Financial planner
    - Experienced defense lawyers

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Patient and Family Engagement

PROBLEM

SOLUTION

PROBLEM

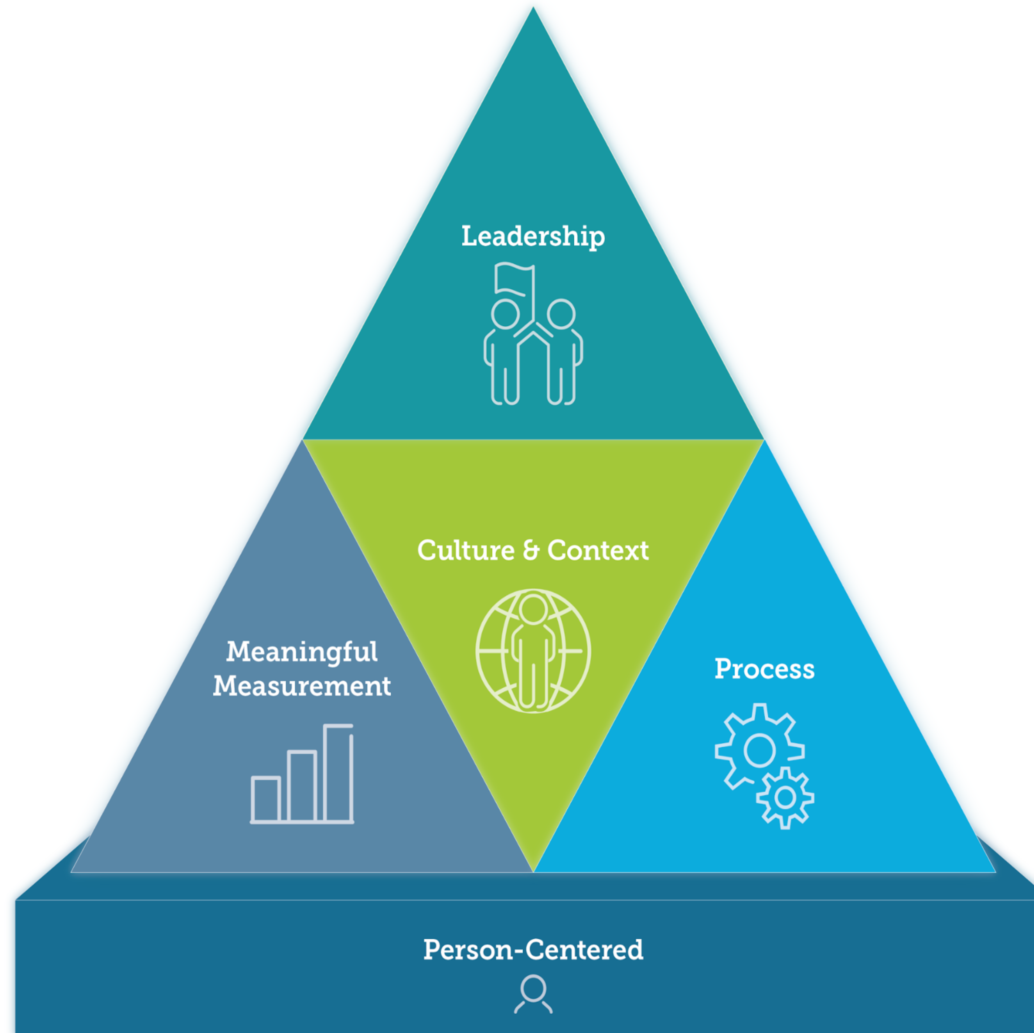
narrative.

Implementation Strategies

Implementing a CRP

1. Engage leadership
2. Understand context and readiness for adoption
3. Use proper metrics
4. Incorporate into organizational workflow

Implementation Framework and Assessment: Leadership, Context and Readiness



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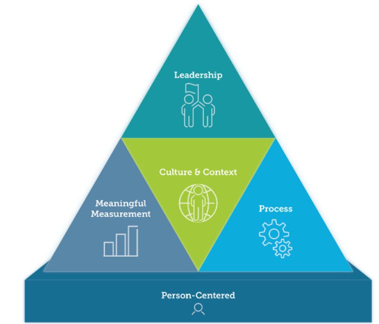
Implementation Framework



Leadership

- **Governance:** The organizational structures and networks that establish the processes of decision making, communication, and the flow of information.
- **Accountability:** Both shared and individual accountability for patient safety with clear goals and roles and responsibilities of team members with a mechanism for feedback.
- **Prioritization:** Commitment to the initiative with the dedication of resources, time, and effort by leadership with alignment of priorities and centralization of resources whenever possible.

Culture & Context

- **Culture:** Leaders set norms and expectations that exemplify a culture of safety: psychological safety, transparency, organizational learning, continuous learning, knowledge sharing, and a just culture.
- **Context:** Initiatives are flexible and adaptable to the local context and the leaders with the implementation team work to improve gaps and leverage strengths while keeping context in mind.

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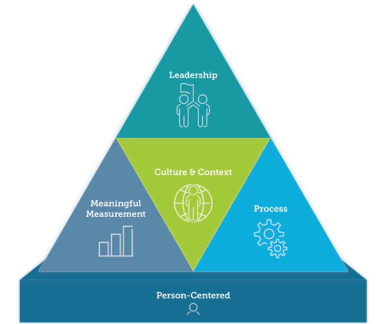
Implementation Framework



Process

- **Engagement:** Leaders are actively involved throughout the implementation process, they champion the initiative and address challenges.
- **High reliability principles:** There is a collective mindfulness of the high reliability principles and they are integrated into patient safety initiatives to create a system that delivers safe care to every patient.
- **Co-creation:** Initiatives are co-created with frontline staff and patient family advisors

Meaningful Measurement

- Measures are streamlined and meaningful to the end-user

Person Centered

- Patient safety initiatives are founded in partnering with people to provide care that incorporates people's values and is in service to the patient.

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CRP Metrics

- Provide opportunity to **improve** implementation
- Create benchmarks for success (& accountability)
- Guide comprehensive, systematic CRP implementation
- Facilitate ongoing reporting, transparent learning & communication

Communication-and-Resolution Metrics

CRP ENVIRONMENT:
- Culture of Safety Survey
- Total number of adverse events

CRP STEPS:
- Timeliness of communication with patient/family
- Event Analysis process
- Peer Support
- Resolution Outcome

MANAGING SERIOUS SAFETY EVENTS
- Communication
- System Improvement

OUTCOMES:
- Number of Claims
- Total Defense Costs
- Patient experience survey
- Provider experience survey

Domain 1: CRP Environment

- **CRP Eligible Event:** Adverse event known to the organization meeting one of the following
  - Harm is judged by the clinical team or institution to be (or have the potential to be) HPI SEC Level PSE 1 or higher
  - Patient reports a harm event described as HPI SEC Level PSE 1 or higher
  - Patient, family, or provider requests that CRP be used to respond to an event (of any severity)
  - Written demand for payment or pre-litigation notice received
- **CRP Actual Event:** A CRP Eligible Event in which the organization used their CRP process (in part or in whole) to respond
- **Serious Safety Event:** A deviation from generally accepted practice or process that reaches the patient and causes severe harm or death

CRP Program Profile

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Implementation Lessons Learned

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Two Fundamental Requirements for Implementation

1 Prioritize the larger landscape

- Must ensure the response to harmed patients is always in service to the larger mission
- Must consciously **normalize** honesty and consistency as part of the organizational culture and clinical performance expectation

2 Clinical leaders must

- Be engaged
- Understand the importance of consistently serving the bigger mission
- Insist that risk, legal adjust their approach to serve the bigger mission and not impede it

Critical Importance to Understand and Operationalize

- All patients are treated with equal honesty,
  - Whether or not they’ve been harmed
  - Whether or not the harm was caused by medical negligence
- The continuum of the patient relationship is characterized by consistency
- Clinical accountability is an important factor to achieving an accountable culture
- An accountable culture is critical to carrying out the clinical mission and reducing harm

Key Effects of a CRP

- Faster clinical improvements
- Measurable improvement in clinical incident reporting
- Richer RCAs
- Peer review-as-patient safety/clinical improvement component
- Improvements to informed consent
- Greater organizational support for evidence-based medicine vs defensive medicine
- Preservation of patient relationships and increased patient loyalty and trust
- Increased joy and meaning in work for caregivers

Reflections

Reflections from each of our Panelists

1. What is the biggest misconception people have about CRPs and why does it matter?
2. What is the most underappreciated ROI of the CRP process, and why does it get overlooked?
3. What is the most important thing an organization should know if it is considering implementing a CRP?

Closing Thoughts

I’m not interested in whether you’ve stood with the great.
I’m interested in whether you’ve sat with the broken.

The Age Of Enlightenment

Audience Questions

Thank you!