Extreme Honesty: 
A Principled Approach to Adverse Events

IHI National Forum
December 7, 2009
A case

- 60 y.o. for CABG
- Case proceeds uneventfully
- Chest closed, skin closure occurring
- Plan for extubation
- Surgeon leaves to speak with family
- Perfusionist hands cell saver blood to anesthesiology resident
- Put under pressure
- Cardiac arrest
- Only resident notices air in line
- What next?

CHEST 2009 Sep; 136(3): 897-903

Disclosing Harmful Medical Errors to Patients
Tackling Three Tough Cases

Thomas H. Gallagher, MD, Sigall K. Bell, MD, Kelly M. Smith, PhD,
Michelle M. Mello, JD, PhD and Timothy B. McDonald, MD, JD
Objectives for the Day

- Identify the barriers and key success factors to succeeding with a principled approach to adverse events that also reduces malpractice impact
  - Model skills that are important to successful practices
  - Describe the evidence and economic experience from the field that support best practices in disclosure and early remediation

Objectives for the Day

- Understand a principled end-to-end response to adverse events
- Appreciate the importance of honest and effective communication following patient harm
- Describe the linkage between transparency and patient safety
• Other objectives?

• Chronology of day’s events
  ▪ Housekeeping
  ▪ Overview of comprehensive response
  ▪ What is “it”?  
  ▪ Types of “disclosures”
  ▪ Educating the next generation
  ▪ Connecting with families and investigating
  ▪ Linking communication with improvements
  ▪ Financial closure
  ▪ Hardwiring the National Quality Forum Safe Practices
  ▪ Wrap-up
Comprehensive Approach to Adverse Patient Events

Data Base

Patient Communication Consult Service

No

Patient Harm?

Yes

Consider “Second Patient” Event Investigation

Hold bills

Inappropriate Care?

Yes

Activation of Crisis Management Team

“Near misses”

Unexpected Event reported to Safety/Risk Management

Process Improvement

No

Full Disclosure with Rapid Apology and Remedy

“it”

Richard C. Boothman
Chief Risk Officer
University of Michigan Health System
Institute for Healthcare Improvement’s National Forum on Quality Improvement in Health Care
Orlando, Fl December 7, 2009

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What is “it”?  

Transparency
In what context?

Transparency = A + B

A = Being honest
B = After unintended outcomes
Why do “it”? 

Why are we doing “it”?

• “it” is the right thing to do
• “it” is the smart thing to do
• Can’t get better without “it”
• “it” is ultimately best for everyone
Who is responsible to do “it”?

• Caregivers
• Risk Managers
• QI
• CEOs
• Board of Directors
• Patients?
In a time of universal deceit, telling the truth becomes a revolutionary act.

George Orwell

Why haven’t we been doing “it”?
It is human nature to avoid danger
It is human nature to deny guilt

For over a century, American physicians have regarded malpractice suits as unjustified affronts to medical professionalism, and have directed their ire at plaintiffs’ lawyers . . . and the legal system in which they operate.

Sage, William
Medical Malpractice Insurance and the Emperor’s Clothes
54 DePaul Law Review 463, 464
March 24, 2005
“Physicians revile malpractice claims as random events that visit unwarranted expense and emotional pain on competent, hardworking practitioners . . .”

Studdert, DM, Mello, MM and Brennan, TA,
Health Policy Report: Medical Malpractice
N Engl J Med 2004; 350; 283

It’s human nature to avoid accountability
“Academic institutions are filled with “A” students. “A” students are not accustomed to taking risks. “A” students are not accustomed to failure. If you see something that needs to be done, just do it. Don’t ask for permission, because no one will give it to you. Tell people you’re doing it – the same thing that prevents them from extending permission will also prevent them from telling you “no”. Just do it. ”

Thomas D. Biggs
July, 2001

Who’s at fault for not doing “it” before now?

- Lawyers
- Patients
- Doctors
- Insurance companies
- Hospitals
- Your parents
- Who else?
It is human nature to always (mostly?) act in our self-interest

Getting started
Agree on principles

Commitment to principles liberates us from fear
Patient Injury Principles

- We will compensate quickly and fairly when inappropriate medical care causes injury.
- We will defend medically appropriate care vigorously.
- We will reduce patient injuries (and therefore claims) by learning from mistakes.

What do you need to do “it”? 
What do you need to do IPSE Institute for Patient Safety Excellence “it”?  

- Backbone  
- Identify the components  
  - Identification of unanticipated outcome  
  - Way of determining the difference between medical mistake and reasonable medical care  
  - Communication  
  - Compensation  
  - Learning from experience  
  - Measurement  
- Secure the resources

“it” is transparency  
- In the context of an unintended patient outcome  
- Responsibility of everyone concerned  
- Because “it” benefits everyone concerned  
- And we shouldn’t be afraid to do “it”
Be courageous

The ultimate irony . . .

Leadership always follows success
The truth will set you free. But first, it will piss you off.

Gloria Steinem
Break time

Back to case

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- Put under pressure
- Cardiac arrest
- Only resident notices air in line
- What next?
How many opportunities for “extreme honesty” or disclosures?

How many disclosures?

- To self
- To peer
- To colleague
- To other caregivers
- To the “system”
- To patient and/or family
Disclosure to Self

Peer Support and the Prevention of the ‘Second Victim’

Importance

- Involved caregivers may experience
  - Intrusive re-enactments
  - Feelings of inadequacy
  - Isolation
  - Ruminative thoughts
  - Burnout
  - Substance Use
  - Depression—which can lead to subsequent errors and decreased quality of life
Psychological Barriers

- Denial of issues/impact
- Resistance to seek help
- Shame and self-blame
- Feelings of isolation
- Fear of consequences for safety/risk inquiry

Challenges

- Institutional support/protection
- Culture of medicine
- Need to ‘automate’ the process
Resources Needed

- Committed leadership for Peer Support Program
  - orientation, materials, and ongoing support for peer volunteers
- Peer support volunteers
  - willingness to provide ‘emotional first aid,’ reliable communicators
- Safety and Risk Management involvement and support
- Link with mental health services / EAP
- Administrative support
  - assistance with orientation, scheduling, contact information
- Persistence and vision

References


Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. *BMJ* 200;320:726-727.
• Disclosure to Colleagues

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Extreme Honesty

- Benefits
- Barriers
- Table exercises

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**Extreme Honesty**

**Benefits**
- Maintain trust
- Learn from mistakes
- Improve patient safety
- Employee morale
- Psychological well-being
- Accountability
- Money

**Barriers**
- Money
- Ego
- Reputation
- Loss of control
- Loss of job, license
- Uncertainty
- Regulatory – data bank
Comprehensive Approach to Adverse Patient Events

Data Base

Patient Communication Consult Service

Patient Harm?

Yes

No

Consider "Second Patient" Event Investigation

Inappropriate Care?

Yes

No

Full Disclosure with Rapid Apology and Remedy

"Near misses"

Unexpected Event reported to Safety/Risk Management

Process Improvement

Activation of Crisis Management Team

"Near misses"
Level 1: Unconscious incompetence
Level 2: Conscious incompetence
Level 3: Conscious competence
Level 4: Unconscious competence
Evolution of "disclosure skills"

Level 1: Unconscious incompetence
Level 2: Conscious incompetence
Level 3: Conscious competence
Level 4: Unconscious competence

So, must have supportive infrastructure

Comprehensive Approach to Adverse Patient Events

Data Base

Patient Communication/Consult Service

Patient Harm?
Yes

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Inappropriate Care?
Yes

Process Improvement

Activation of Crisis Management Team

No
Educating the next generation of caregivers

Disclosure Video
"You should've seen the look on our faces when we realized that we'd been looking at the x-rays backward for the first hour of surgery."

Definition of Professionalism

AAMC & NBME:

- Altruism
- Honor and Integrity
- Caring and Compassion
- Respect
- Responsibility
- Accountability
- Excellence and Scholarship
- Leadership
Definition of Professionalism

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Adverse Event Reporting & Disclosure

- Did not learn from the adverse event
  - Institution
  - Individual
Education

- Knowledge
- Skills
- Behaviors, Attitudes
- Assessments

Seven Pillars Education:
Adverse Event Reporting & Disclosure

- Knowledge
  - Content, materials, readings - common set
- Skills
- Behaviors, Attitudes
- Assessments
May, 2008

Assessing the core competencies
Open and Honest Communication

- **What patients want:**
  - Their questions answered truthfully
  - An apology if appropriate
  - Not to be abandoned
  - Remedy; benevolent gestures
  - Assurances to prevent similar another AE
The Many Faces of Error Disclosure: A Common Set of Elements and a Definition

SP Fein, et al

1. Full disclosure
2. Nondisclosure
3. Partial disclosure
4. Connect the dots
5. Mislead
6. Defer

The Many Faces of Error Disclosure: A Common Set of Elements and a Definition

SP Fein, et al

1. Admission
2. Discussion of the event
3. Link to proximate effect
4. Proximate effect
5. Link to the harm
6. Harm
The Many Faces of Error Disclosure: A Common Set of Elements and a Definition

SP Fein, et al

- “Because of an error on my part, you got your diabetic medications when you shouldn’t have. I apologize for that. It caused you to have very low blood sugar, which caused you to have a seizure at which time you fell out of bed and broke your hip”.

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Seven Pillars Education:
Adverse Event Reporting & Disclosure

- Knowledge
  - Content, materials, readings - common set
- Skills
  - Actions, procedures, demonstrations
- Behaviors, Attitudes
- Assessments
Communication Skills Training

- Challenges
  - Many levels of disclosure
  - Appreciate uniqueness
  - Not for everyone
  - Hard to prepare staff for “Heat of Battle”
  - Resource intense

- Opportunities
  - Use of simulation
  - Validated communication skills teaching tool
  - Emotional and stressful scenarios
  - Debriefing and reflection
  - Team dynamics
  - Assessment tool
  - Confident and competent
Communication Skills Training

Simulation - Standardized Patients

- Case-based roll-plays
- Team training and learning
- Videotaping
- Debriefing and reflection
- Consensus building and improvement
Seven Pillars Education: Adverse Event Reporting & Disclosure

- **Knowledge**
  - Content, materials, readings - common set
- **Skills**
  - Actions, procedures, demonstrations
- **Behaviors, Attitudes**
  - Culture, beliefs, role-modeling
- **Assessments**

Seven Pillars Creating the Culture: Adverse Event Reporting & Disclosure

- **Teach it**
- **Expect it**
- **Hire to it**
- **Establish/train to a standardized process for reporting**
- **Establish/train to a “just culture” for the organization**
- **Demonstrate that you treat those who disclose fairly**
- **Demonstrate that you support those involved in AE’s**
- **Teach that it is the right thing and smart thing to do**
**Seven Pillars** Education:
Adverse Event Reporting & Disclosure

- **Knowledge**
  - Content, materials, readings - common set

- **Skills**
  - Actions, procedures, demonstrations

- **Behaviors, Attitudes**
  - Culture, beliefs, role-modeling

- **Assessments**
  - Tools – Exams, surveys, simulations, qualitative report analysis, observational audits, debriefings, feedback

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**Open and Honest Communication**

Fifth Annual Roundtable:
“*Designing, Implementing & Assessing a Patient Safety Health Science Curriculum*”
July 13th – July 17th 2009
Telluride, CO
University of Illinois offers Patient Safety Program Online

Online Master of Science & Graduate Certificates in Patient Safety

The University of Illinois College of Medicine at Urbana-Champaign's Global Campus offers an online Master of Science degree in Patient Safety Leadership, a certificate in Patient Safety Leadership, and a certificate in Patient Safety Leadership and Quality Improvement in 2016.

The online Patient Safety Leadership program builds on the experience of a team of experts in the field of patient safety. Students will learn about the latest in patient safety research and will be prepared to lead and manage change in healthcare organizations.

Coursework:
- Foundations of Patient Safety
- Communication and Collaboration
- Patient Safety Leadership and Quality Improvement
- Patient Safety Research and Data Analysis
- Patient Safety Policy and Environment
- Leading Change and Creating Change

For more information, contact Lara Gunderman, program director, at 312-569-6343 or gunderman@uiuc.edu

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Comprehensive Approach to Adverse Patient Events

Unanticipated Event reported to Safety/Risk Management

- Unexpected Event
- Patient Harm?
- Yes
  - Consider "Second Patient" Event Investigation
  - Yes
    - Full Disclosure with Rapid Apology and Remedy
  - No
  - Inappropriate Care?
    - Yes
      - Activation of Crisis Management Team
    - No
      - Process Improvement

- No
  - Data Base
Family Contact

Nikki Centomani
&
Susan Anderson

- Initial disclosure by providers/designees once stabilization occurs
- Advise Patient Care Director/Nursing Manager, to monitor patient and ongoing needs. They can provide ongoing reports and let you know of any further concerns
- Maintain contact with Guest Services to serve as Patient Advocate/Liaison, or have RM staff maintain contact
Family Contact

- When patients and families ask for copies of the records be prepared to share the pertinent documentation per your Record Release policy.
- May want to share your business cards, and information on your program with patients and families.

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Family/Patient Needs

- Patients and relatives want to prevent similar incidents (changes to the system).
- Need for explanation on what occurred.
- Accountability.
- Greater honesty and appreciation of severity and full scope of situation.
- Many are suspicious of cover-up.

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Family/Patient Needs

- Important to establish credibility with honest and frequent interactions
- Need to manage expectations which should begin at the initial interaction
- Be clear with philosophy of your program and always adhere to your principles

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Family/Patient Needs

- Assist with immediate needs if concern for unreasonable care
  - Hotel, meals, parking, transportation
  - Out-of-Pocket expenses
- Assist with return of functional level
- If the timeline for review is long/complex - consider income loss, need for ADL funding.
- Bills handled and possible compensation

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Event Response

KEY: Immediate action required.
Event Response

- Reporting
- Stabilization
- Preserve Information
- Immediate Debriefing
- Notifications
- Disclosure
- Ongoing Evaluation
- Family Contact

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Unexpected Event Response

- Foundation of any Program is timely reporting of events with injury
- Reporting may be calls to office, pages or electronic
- Electronic reporting: set Alerts for injury levels and/or event types
- Capture all calls and reporting in one system for aggregate reviews

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Immediate stabilization of needs
- Clinical
- Extra testing
- Sequester devices, monitor strips, download device histories, fetal strips, cord gases, placentas
- Staff support
- Photos of equipment and event scene

Sequester all equipment/devices - do not move, turn off, or change equipment or settings
- Contact Clinical Engineering as required for assistance
- Secure all disposables, i.e. medication vials, IV bags, catheters, etc.
- Obtain all records: medical record, departmental worksheets, logs (transports), and schedules (OR)
Preserve Information

- Note any evidence of additions, corrections, or alterations in the medical record
- Obtain all monitoring strips/records if applicable
- Secure record of pages via Operator
- Secure photos/video recordings (OR/procedural) and/or security monitoring tape

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Immediate Debriefing

Based on who, what, when, where, why, and how

- Conducted in group or individually
- Contact the Unit Director and/or Program Director of each employee to be interviewed
- Use medical records and other documents during interview to establish timeline of events (Note discrepancies throughout the process, deferring judgment)

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Immediate Debriefing

- Provide “Care for the Care Provider” information as needed
- Provide interviewees with contact information/business card
- Summarize each interview as soon as it concludes, noting impressions

Notifications

- To family or significant others as directed by Patient/legal documents
- To Providers who are not in immediate vicinity
- To leadership, per system protocols
- To Public Relations, if applicable
- To insurance carrier, if applicable
Disclosure – Issues

- Who should tell family?
- What should be disclosed?
- When should it occur and whom else should be present?
- How should discussion take place?
- What should be documented?
- Where will the meeting take place?

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Disclosure Guidelines

- Gather all necessary facts
- Presume good will on behalf of all parties
- Approach the disclosure with intelligent honesty
- Input from the patient/family is valued
- Do not speculate on causes or reasons for the event-communicate known facts
- Be prepared with answers to anticipated questions and tell them we will get back to them after additional review

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Disclosure Guidelines

Apply “Four Agreements” (by Don Miguel Ruiz):
- Be impeccable with your word
- Make no assumptions
- Do not take anything personally
- Always do your best
- Follow up meetings should always be held to provide updates to review
- Patients and Families are very forgiving of error but not of dishonesty

Disclosure Contents

- What happened- Only facts, Apology if applicable
- How it happened- Acknowledge the event
- Why it happened- To the best of your knowledge
- What the professional or facility is going to do to assist the patient and family
- What steps have been or will be taken to reduce the likelihood of this happening in the future
- Future contacts
Ongoing Evaluation

- Develop strategy for ongoing investigation and identify additional staff to be consulted/interviewed
- Consider application of National Patient Safety Goals and “Never Events”
- Review applicable system policies, procedures, guidelines and past similar reported events
- Flow chart process if applicable

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Ongoing Evaluation

- Obtain literature review and collect data for intimate knowledge of clinical care delivery for the event reviews if applicable
- Process for Peer Review referral if applicable
- Present key issues which ascribe Duty, Breach, Causation, and Injury to Leadership (RM Director and Chief Safety and Risk Officer for Health Affairs)

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Managing the Financial Impact

- Appropriateness of care
- True cost of harm
- Realization Rates
- Professional fees
- Hospital fees

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Operational Process

- Future care
- Patient Safety Compensation Card
- Registration alerts
- Patient Safety Hotline

©2009
For What are We Accounting?

- Benevolent gestures
- Attribution of waived charges
- “Risk Management Cost Center”
- Assessing liability
- Incentives for improvements
- Methodology

Journey Lessons

- Some patients and families will remain angry despite our best efforts
- Many patients and families do not want compensation if treated honestly and openly
- Most event determinations on preventability are not quick
- Many providers need stronger listening skills
- Important to share the Lessons Learned as well as Success Stories internally and externally
How many disclosures?

- To self
- To peer
- To colleague
- To other caregivers
- To the “system”
- To patient and/or family
Comprehensive Approach to Adverse Patient Events

1. Data Base
   - Patient Communication Consult Service
   - Consider "Second Patient" Event Investigation
     - Inappropriate Care?
       - Yes: Activation of Crisis Management Team
         - "Near misses"
       - No: Full Disclosure with Rapid Apology and Remedy
     - Event Investigation
   - Unexpected Event reported to Safety/Risk Management
   - Process Improvement

Disclosure is a process: not an event

- Patient harm
  - Investigation
  - First visit or "informed consent"
  - First discussion
  - Ongoing discussions
Break the compensation barrier and prove the return on investment

. . . it’s the *smart* thing to do

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Prepare for a new paradigm
When an explanation is needed, every day that passes further cements mistaken beliefs

When an apology is truly owed, every day that passes results in a new injury

Q: I can tell you after 30 years in this business, the University’s approach was sort of a new approach, like nothing I’ve ever seen before. What difference did it make to you?

A: Well, I felt that I had been wronged, that I had this lump and no one took me seriously. And after my diagnosis, I was kicking myself for not being more assertive. But that night, when I talked to all these important people from the University, I know they finally listened. And if the whole process had ended that night, it would have been fine with me, because I finally stood up for myself and they paid attention, they truly felt sorry their doctor did not take me seriously when I complained about my breast mass. If it all ended that day, I would have been satisfied.
Q: How do you know that they listened?

A: The U of M staff, they were very forthcoming about the fact that the care I received was not appropriate and they apologized and made no excuses. They said simply their doctor should have done better and they were sorry.

I cherish that meeting even now, and the money paled in comparison.

By providing an alternative to litigation, health systems and caregivers control the compensation dialogue

Health systems and caregivers gain a tremendous advantage when they approach compensation honestly
• **Principles: commit to pay what you owe**

• **It takes a team:**
  - Investigatory and experts
  - Structured settlement specialist
  - Financial planner
  - Medical and occupational economist
  - Life care planner
  - Insurance specialist

• **Seek first to understand, before you seek to be understood**

• **Tailor offer to patient’s needs**

• **Communicate with explanation/rationale**

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**Plaintiff’s lawyer’s experience**

“Instead of adversarial, it was conversational. It was instead of trying to figure out what claims and defenses needed to be, I found myself trying to figure out some higher calling, what’s the right thing to do here? What’s the best thing to do here? My role changed from advocate to warrior to counselor is the best way that I can describe it. We are attorneys and counselors and the counselor part got emphasized, in fact, became the dominant, the ascendant part just as soon as it became clear the University Hospital was gonna take a different approach to this case.”
Flags signaling significant shift in culture:

Claim-to-lawsuit ratio shifts

Change in Quality of Conversation

Abandonment of Contingency Fee?

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It’s a challenge to prove the financial benefit when every case is different, when the claims tail delays measurable benefits, when the whole business is so laden with emotion, when the fear of litigation obscures the more important goal of patient safety

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Create Correct Expectations

- Attorneys’ fees and costs will rise first
- Risk Management budget will rise
- Have a plan for attacking claims with long-range expectation of:
  - Reduction in claims
  - Reduction in transactional expenses
  - Reduction in elapsed claims time
  - Reduction in wasted physician time
  - Increase in physician satisfaction
  - Improvement in claims results as measured by performance measures
- Be careful not to promise reduction in payouts in the short run

Anticipate stereotypes and urban legends and dispel them

Don’t expect audience to understand your business
*Caveat on Costs

- Complicated issue
- Cannot use attorneys fees/costs as simple gauge of success
- Cost/benefit analysis must include:
  - Cost of infrastructure improvements/HR costs necessary to infuse pro-activity
  - Impact to staff re: productivity, morale, staff retention
  - Public relations value/cost
  - Present spending for future claims reductions through improved patient safety and communication
  - Opportunity/investment costs associated w/high insurance reserves

Simple end-of-the-year tabulation:

- 2001 $2.2 million
- 2002 $3.1 million
- 2003 $2.9 million
- 2004 $2.7 million
- 2005 $2.3 million
When paired up with the occurrence year however, (matching fees and costs with the years in which the care at issue occurred):

- 1999  $3,083,792
- 2000  $2,474,771
- 2001  $2,380,087
- 2002  $2,201,608
- 2003  $1,123,636

### Legal Expense Paid

<table>
<thead>
<tr>
<th>Year Claims Closed</th>
<th>Ave legal expense per closed claim</th>
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<tbody>
<tr>
<td>1998</td>
<td>$60,000</td>
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• Dropped from $48,000 in 1997 to $21,000 in 2003
• Legal expenses per indemnity dollar paid dropped sharply
• Reserves cut by 75%
• Opening to closing times fell from an average 20.7 months to 9.5 months and it’s still dropping
Other Performance Measures

- Claims filed
- Activity tracked
- Settlement authority vs actual disposition
- Case evaluation comparison
- Measuring physician’s time commitments
- Verdict comparisons
- Trial record
- Physician approval
- Patient satisfaction

- In August, 2001 we had 262 claims and suits.
- In August, 2002 we had 220 claims and suits.
- In August, 2003 we had 193 claims and suits.
- In August, 2004 we had 155 claims and suits.
- In August, 2005 we had 114 claims and suits.
- In August, 2006 we had 104 claims and suits.
- In August, 2007 we had 83 claims and suits.
- In August, 2008 we had 81 claims and suits.
Claims opened per calendar year

- 1999: 136
- 2000: 122
- 2001: 121
- 2002: 88
- 2003: 81
- 2004: 91
- 2005: 85
- 2006: 61

Don’t oversell
Don’t lose focus

Claims are affected by several factors – important to back into this: can’t claim transparency caused reduction, but CAN claim no catastrophes while reaping other benefits
• Compare actual results against settlement authority extended
• Compare actual results against Case Evaluation assessments

Other Performance Measures

Settlements Compared to CMC Authority
Cases Settled in 2002, 2003

Settlements Compared to Case Evaluations
closed cases evaluated in 2002/03
- Can compare results to last settlement demand
  - E.g., “Tried Jones v. Regents to no cause for action. Last settlement demand before trial was $500,000. Cost of trial was $125,000. Resulted in $350,000 savings.”

- Can compare against jury verdict/settlement reports published or procured from service

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**Experienced Approach in Practice**

**SETTLEMENTS**

**Begley, John:** Failure to conduct either a CT scan or an ultrasound prior to taking the patient into surgery for a suspected ruptured abdominal aortic aneurysm. No aneurysm found and post op had significant abdominal wound complications. Case evaluation was $150,000. Settled for $65,000.

**Belanger, Steven:** Death of 32 year old husband and father of three young children following surgery for extensive injuries from snowmobile accident including pelvic and femur fractures and degloving of lower extremity. Alleged anesthesiology failure to maintain appropriate fluid levels resulting in cardiac arrest and death. CMC authority of $4 million granted; case settled for $2.5 million.

**Hoesl, Rebecca:** Bowel perforation during the performance of a laparoscopic cholecystectomy and alleged failure to diagnose perforation resulting in sepsis, prolonged hospitalization and persistent and chronic wound infection requiring multiple surgeries. CMC authority extended to $500,000; case settled for $450,000.

**Safley, Robert:** Death due to alleged deficient treatment of severe liver injury, failure to respond to drop in hemoglobin, failure to treat an abscess near the liver. Case evaluation was $450,000, last settlement demand was $550,000, judgment after trial was $215,000 ($150,000 verdict plus costs and interest). Case settled for $190,000.

**Tchorzynski, Joseph:** Failure to timely diagnose pituitary tumor resulting in partial loss of vision in young man. Case evaluation was $380,000, CMC authority extended to $320,000. Case settled for $236,000.

**Davison, Randy:** Negligent harvesting of median nerve instead of palmeris longus tendon in repair of severed dominant hand tendons following car accident in 41 year old photographer. Litigation was avoided by creative settlement approach utilizing interim settlement while results of nerve grafting awaited, followed by negotiations and arbitration if necessary. Initial interim payment of $200,000 following nerve grafting, final settlement reached for an additional $225,000 for a total of $425,000. CMC authority granted to $450,000 total. Savings included costs of litigation.
Experienced Approach in Practice

Savings monthly: e.g., $1,744,000 savings from settlement authority extended in the month of May alone.

(See Status Updates from Monthly Report)

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Principled approach in practice

- Tried 7 cases between August, 2001 and September, 2002.
- Total exposure (assuming all seven were lost): est. $7.5 – 8.5 million
- Won 6 outright. Lost 1, but verdict ($150,000) far below settlement demand ($550,000) and was recently settled.
- Cost of settling all seven: est. $2.5 million
- Cost to try all seven: est. $320,000
  $2 million savings
Continue to focus on long range gains while you’re finding your way in the short run.

Work hard to publicize your story

- Governing board meetings
- Faculty meetings
- Administration meetings
- Monthly reports
- Honor those who pay the bills with full information about how their money is being spent, treat it like informed consent and consciously keep lean
- Have no ego in the budget
Confront costs directly and sell the value

Don’t hide your light . . . describe the mission and your activity to all your constituencies

Put numbers in context
Money is better spent in Risk Management than with outside counsel
Evolution of Risk Management

2002 - 2007

- Institutional role defined and expanded
  - Acute event support for staff, preserve evidence, intervene with patient/families
  - Investigational support for sentinel/serious adverse events, claims and privacy complaints
  - Risk reduction strategies including education, risk management, support for contracting, patient safety and quality efforts
  - Data support for patient safety, credentialing, claims
  - Patient “terminations” 250 – 300 a year

- Volume and scope of work has increased

- Staff entirely revised to fit new roles

Evolution of the RM Budget

2002 – 2007

- Increased quality
  - Overhauled staff w/technically competent, medically experienced staff
  - Trained in claims and mediation techniques
  - Added dedicated education and data specialists

- Increased quantity
  - Level of every activity has expanded dramatically
### Evolution of the RM Budget

#### 2002 – 2007

<table>
<thead>
<tr>
<th>Category</th>
<th>2002</th>
<th>2006</th>
<th>2007</th>
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<tbody>
<tr>
<td><strong>Claims histories</strong></td>
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<td><strong>Events reported</strong></td>
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<td><strong>Educational programs</strong></td>
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<td><strong>Privacy investigations</strong></td>
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<td><strong>Difficult patient terminations</strong></td>
<td>250 – 300 annually</td>
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<tr>
<td><strong>Employees</strong></td>
<td>9</td>
<td>17</td>
<td>26</td>
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</table>

- **Risk Monitor Pro training**
  - 520 individuals trained
  - 35 presentations to groups not including the Nursing Blitz

- **Multiple reports – growing**
  - OCA events
  - Falls, medication errors, skin ulcers

- **Committees – direct support**
  - P&T, MedSafe, Peds Med Safety, Falls Data Group, Lab Specimen Report Group, SMDA, Ambulatory Care, Quality Improvement, RM Liaisons, OMP Metrics, FMEA, Infection Control, etc.

- **MLRC/CMC**
Evolution of the RM Budget 2002 – 2007

- **Litigation support**
  - Claims approach based on a) pro activity and b) knowing the difference between reasonable and unreasonable care and, c) understanding if the outcome was adversely affected
  - Requires skill, expertise, time to intervene with patients, families and staff – high anxiety
  - Requires attention to detail, experience, expertise to understand the medical issues
  - Transferred cost formerly paid to outside counsel – defraying costs even in litigated cases
  - MLRC incredibly time-consuming
  - Secondary benefit: claims experience = improved risk management support

Demonstrate responsibility and accountability
Cost Containment Initiatives

- Cut non-essential travel
- Kept office staff to minimum
- Using temporary, low-cost work study, high school labor where possible
- Instituted performance-based compensation
- Cut non-essential meetings and discouraged “double-teaming”
- Increased early resolution efforts, early claims reviews and litigation support

Future of the RM Budget 2002 – 2007

- Initiatives
  - Support for peer review on department levels and MSQC
  - Patient safety indicator project
  - Liaison to OR
  - Liaison to PSAC
  - Increased support for Compliance Office
  - Special institutional educational projects including Patient Safety Video project, M-Learning module, GME educational support, mock depositions
  - Increased support for business venture risk management
Truthfully, it’s not about claims, apologies, law suits at all.

Collateral Benefits

Clinical Improvements
Clinical Improvements Derived
Directly from Claims

• initiation of the on-line incident reporting system
• establishment of a patient safety contingency fund
• development/enforcement of real peer review
• formation and deployment of rapid response teams
• the emergence and growth of a large hospitalist service
• utilization of patient safety coordinators
• changes in clinical staffing and supervisory designs
• pulmonary embolus research to identify patients at risk on admit
• purchase of walkie-talkie devices to streamline communications between treatment teams
• pulse oximetry for all adult and pediatric inpatients
• purchase of portable “vein sensors”

Collateral Benefits

Faculty satisfaction and retention
• Of more than 400 responses:
  ▪ 87% said that the threat of litigation adversely impacted the satisfaction they derived from practice
  ▪ 98% perceived a difference in approach post 2001
  ▪ 98% approved of new approach
  ▪ 55% said that the new approach was a “significant factor” in their decision to stay at UMHS
  ▪ Only criticism was that they want more risk management attention

• Counted hours MDs spent with lawyers in litigated cases over 15 cases
• Discovered average of 100 hours spent with lawyers
• Actual time probably 2x – 3x
• Can apply to average hourly return and arrive at benefit of keeping MDs out of litigation
ACTUARIES – Understand the species

- Most concerned about what they DON’T know
- Inherently distrustful
- Most will not make an effort to:
  - Understand what you’re doing
  - Understand the benefits
  - Believe that you’re different
- Takes years to get their confidence, so start now
- And try NOT to get frustrated with them
MEDICAL PROFESSIONAL LIABILITY
Comparison of Ultimate Losses

- Estimated Ultimate Losses based on data as of December 31, 2004
- Estimated Ultimate Losses based on data as of December 31, 2002

Gain = $10.9MM

[1] Based on University of Michigan data.

Graph 3A

MEDICAL PROFESSIONAL LIABILITY
Estimated Ultimate Losses per Exposure Unit

- Estimated Ultimate Losses per Exposure unit
- Fitted Growth at 6%

[1] Based on University of Michigan data.

Graph 3B
Take home message: control the message

Driving Institutional Change with Lessons Learned from Claims

Richard C. Boothman
Chief Risk Officer
University of Michigan Health System
Institute for Healthcare Improvement’s
National Forum on Quality Improvement in Health Care
Orlando, Fl December 7, 2009

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Every day, we allow self-interest, personal comfort, intransigence, inertia, confrontation aversion, shallow thinking, financial motivations, personal gain and a host of other forces to trump patient safety and put patients at risk.

Need to undo stereotypes
Need to step backwards to core values, then think creatively

Barriers

- Legal misconceptions
  - We’ve been denying and defending for so long, most of the time no one has checked the law, there’s often no precedents

- Turf and pockets of insecurity
- Confrontation aversion and its cousin, inertia
- Investments in redundancy
The very best risk management is to make no medical mistakes

“Deny and defend” and learning from mistakes are mutually exclusive

UM Claims Management Model
1985-2002

- Claim Received
- Litigation
- Medical Review Committee
- Assign to Counsel
- Litigate
- Claims Committee
- Settle or Trial?
- COURT HOUSE
  - Or more often, courthouse steps
Still, the reality is that at the University of Michigan Health System, a patient’s complaints, lodged in different places can literally generate investigations and responses from five different offices with little coordination.
Peer Review

Plastic surgeon

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<td>3/15/99</td>
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The problem of old lions...

- 54 y/o, obese married woman w/hx of HTN, primary hyperaldosteronism w/good medical control of blood pressure taken to surgery for adrenalectomy to try for cure
- 11/26/01: elective adrenalectomy via laparoscopic surgery
- Surgeon encountered problems with bleeding and the patient exsanguinated
- Resuscitation was unsuccessful

Claims History

- 1/8/91
- 9/8/92
- 4/14/94
- 12/9/94
- 10/15/98
- 4/07/00
- 5/26/00
- 8/20/01

- Heart Attack – November, 1999
- Two brain damaged babies
- One brain damaged mom
- $6.6 million dollars
- Three devastated families
- One devastated doctor
Investigation revealed:

- Surgeon was not regarded as competent by colleagues
- For several years, Anesthesiology altered staffing due to higher risk for this surgeon
- Every time this surgeon appeared on the OR schedule, clerks ordered extra blood – for 6 years
- Superiors and residents knew for years that this surgeon was no longer safe. No attempt to limit privileges
- Extreme Honesty: the principled approach to adverse events.
- Linking to the National Quality Forum Safe Practices

Why we do this..........................
• **Objectives for the Day**
  - Identify the barriers and key success factors to succeeding with a principled approach to adverse events that also reduces malpractice impact
    - Model skills that are important to successful practices
    - Describe the evidence and economic experience from the field that support best practices in disclosure and early remediation