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Extreme Honesty: A Principled Approach to Adverse Events

IHI National Forum
December 7, 2009

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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

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- **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

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- **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

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- **Other objectives?**

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- **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

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Comprehensive Approach to Adverse Patient Events

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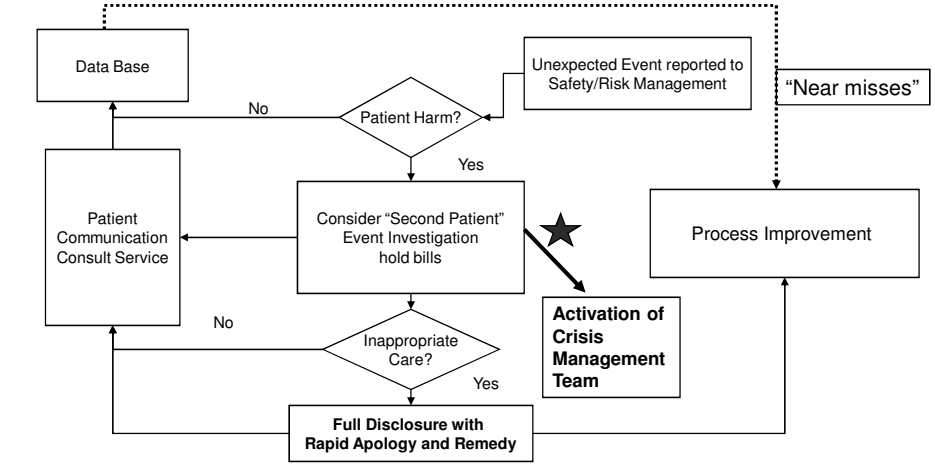

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"it"

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”?

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Transparency

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In what context?

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Transparency = A + B

A = Being honest

B = After unintended outcomes

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Why do "it"?

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Why are we doing "it"?

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- **"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**

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Who is responsible to do "it"?

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Who is responsible to do "it"?

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- **Caregivers**
- **Risk Managers**
- **QI**
- **CEOs**
- **Board of Directors**
- **Patients?**

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In a time of universal deceit, telling the truth becomes a revolutionary act.

George Orwell

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Why haven't we been doing "it"?

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It is human nature to avoid danger

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It is human nature to deny guilt

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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

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"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

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It's human nature to avoid accountability

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"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

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Who's at fault for not doing "it" before now?

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- **Lawyers**
- **Patients**
- **Doctors**
- **Insurance companies**
- **Hospitals**
- **Your parents**
- **Who else?**

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It is human nature to always (mostly?) act in our self-interest

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Getting started

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Agree on principles

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Commitment to principles liberates us from fear

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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.

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What do you need to do “it”?

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What do you need to do "it"?

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- **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**

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- "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"~~

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Be courageous

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The ultimate irony . . .

Leadership always follows success

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The truth will set you free. But first, it will piss you off.

Gloria Steinem

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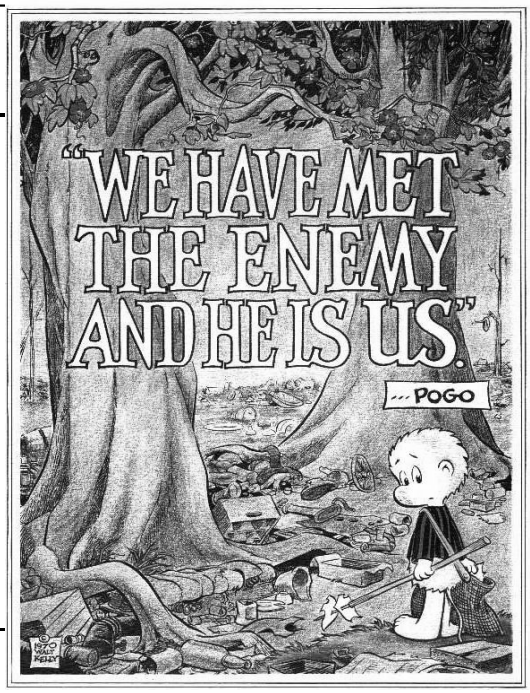

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for Patient Safety Excellence

Walt Kelly 1970

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Break time

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Back to case

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- 60 y.o. for CABG
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- Put under pressure
- Cardiac arrest
- Only resident notices air in line
- What next?

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How many opportunities for “extreme honesty” or disclosures?

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How many disclosures?

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

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Disclosure to Self

Peer Support and the Prevention of the 'Second Victim'

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Importance

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- 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

Gazoni FM et al. Life after Death: The aftermath of perioperative catastrophes. *Anesth Analg* 2008;107:591-600.

Scott SD et al. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Qual Saf Health Care* 2009;18:325-330.

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

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- **Disclosure to Colleagues**

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Back to case

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How many disclosures?

- To self
- To peer
- To colleague
- To other caregivers
- To the "system"
- To patient and/or family

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Extreme Honesty

- **Benefits**
- **Barriers**

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- **Table exercises**

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Extreme Honesty

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- **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

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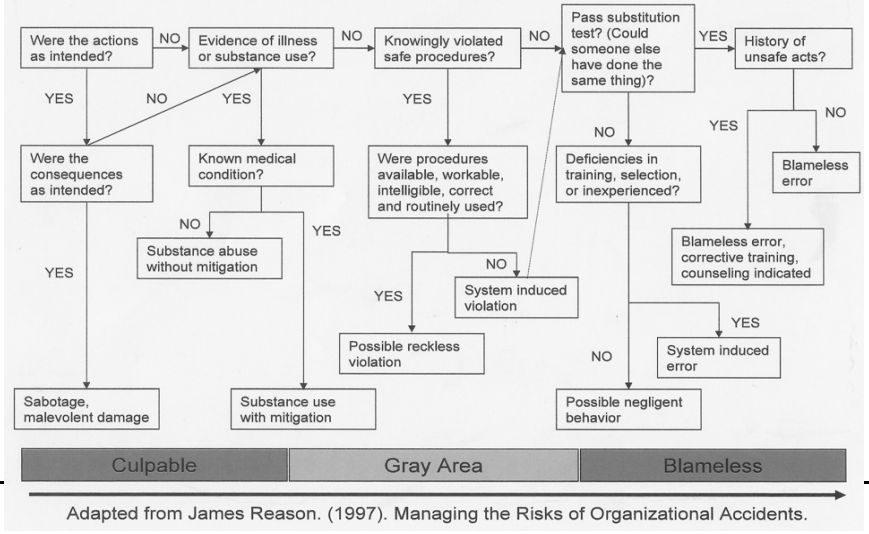
UNSAFE ACTS ALGORITHM



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

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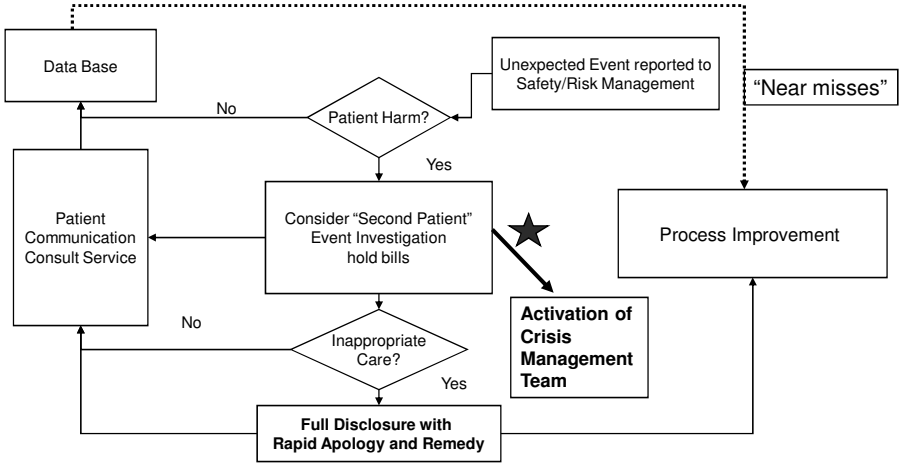

Evolution of "disclosure skills"

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

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Evolution of "disclosure skills"

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

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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

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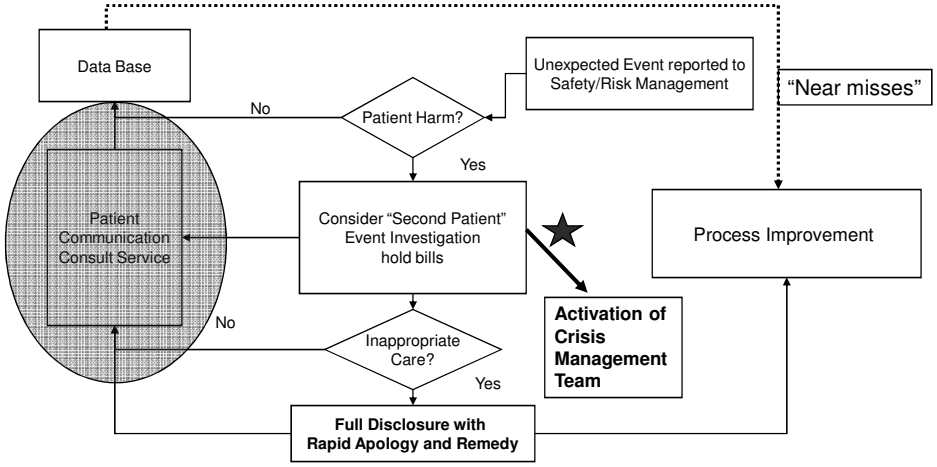

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Educating the next generation of caregivers

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Disclosure Video

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"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."

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Definition of Professionalism

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AAMC & NBME:

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

Definition of Professionalism

AAMC & NBME:

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- Leadership

Adverse Event Reporting & Disclosure

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

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Education

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- **Knowledge**
- **Skills**
- **Behaviors, Attitudes**
- **Assessments**

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Seven Pillars Education: Adverse Event Reporting & Disclosure

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

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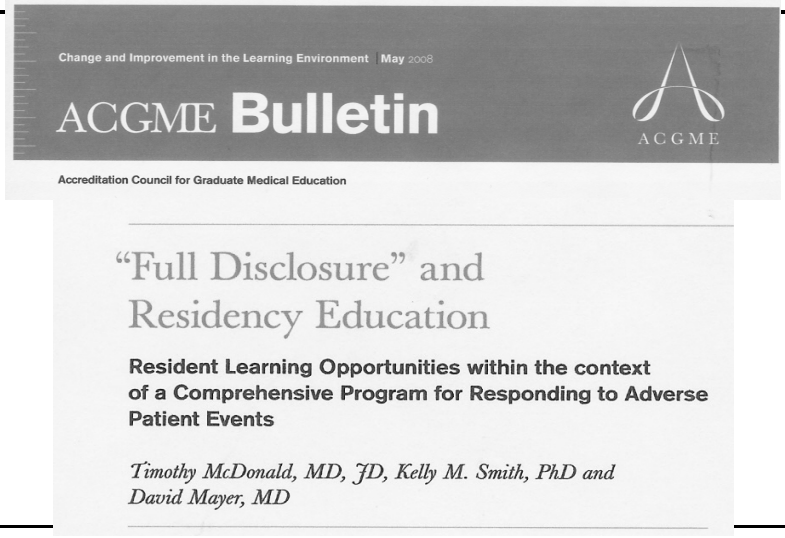

Change and Improvement in the Learning Environment | May 2008

ACGME Bulletin

ACGME

Accreditation Council for Graduate Medical Education

"Full Disclosure" and Residency Education

Resident Learning Opportunities within the context of a Comprehensive Program for Responding to Adverse Patient Events

Timothy McDonald, MD, JD, Kelly M. Smith, PhD and David Mayer, MD

May, 2008

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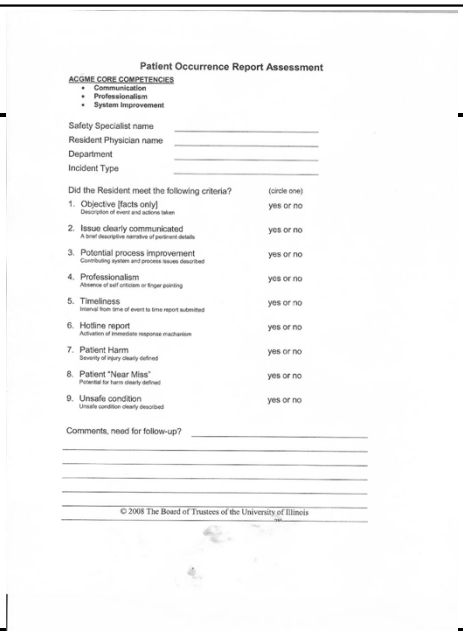

Patient Occurrence Report Assessment

ACGME CORE COMPETENCIES
- Communication
- Professionalism
- System Improvement

Safety Specialist name _____
Resident Physician name _____
Department _____
Incident Type _____

Did the Resident meet the following criteria?	(circle one)
1. Objective [facts only] Description of event and actions taken	yes or no
2. Issue clearly communicated A brief descriptive narrative of pertinent details	yes or no
3. Potential process improvement Contributing system and process issues described	yes or no
4. Professionalism Absence of self criticism or finger pointing	yes or no
5. Timeliness Interval from time of event to time report submitted	yes or no
6. Hotline report Activation of immediate response mechanism	yes or no
7. Patient Harm Severity of injury clearly defined	yes or no
8. Patient "Near Miss" Potential for harm clearly defined	yes or no
9. Unsafe condition Unsafe condition clearly described	yes or no

Comments, need for follow-up? _____

Assessing the core competencies

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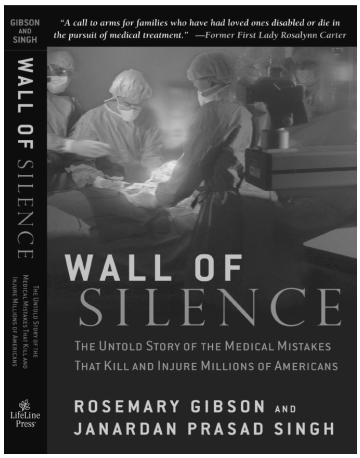

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Open and Honest Communication

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- **What patients want:**
  - Their questions answered truthfully
  - An apology if appropriate
  - Not to be abandoned
  - Remedy; benevolent gestures
  - Assurances to prevent similar another AE

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Communication Skills Training

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

SP Fein, et al
Soc Gen Int Med 2007;22:755-761.

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

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Communication Skills Training

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

SP Fein, et al
Soc Gen Int Med 2007;22:755-761.

1. Admission
2. Discussion of the event
3. Link to proximate effect
4. Proximate effect
5. Link to the harm
6. Harm

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

SP Fein, et al
Soc Gen Int Med 2007;22:755-761.

- "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**

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Communication Skills Training

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

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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

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Communication Skills Training

Simulation - Standardized Patients

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Communication Skills Training

- Case-based roll-plays
- Team training and learning
- Videotaping
- Debriefing and reflection
- Consensus building and improvement

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Seven Pillars Education:
Adverse Event Reporting & Disclosure

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

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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

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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

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University of Illinois Global Campus

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Online Master of Science & Graduate Certificates in Patient Safety

University of Illinois offers Patient Safety Program Online

The University of Illinois College of Medicine at Chicago and U of I Global Campus will launch an online Master of Science Degree in Patient Safety Leadership, a certificate in Patient Safety and Medical Error Disclosure, and a certificate in Patient Safety Organizations in 2008.

The online Patient Safety Leadership program will enable learners and health care organizations to affect positive change in all aspects of patient care, from the bedside to facility design; including administration, academia, government, accreditation and clinical associations. With hospitals and health care organizations increasingly developing and implementing new patient safety practices, health care professionals will benefit from the professional credentials earned in the Patient Safety Leadership program.

Quality Online Education

With a learner-focused environment, students will benefit from the focus on inter-professional teamwork, simulation training, communication and collaboration, medical error science, organizational change, and health care leadership in a culture of safety.

Each course will be eight weeks in length. The MS in Patient Safety Leadership will require eight courses, and each certificate will require three courses. All certificate courses can be used toward the master's degree if the student is accepted into the graduate program.

By taking courses back-to-back, students may complete the master's degree program in as few as 16 months, and the certificates in as few as six months.

Curriculum

The curriculum of the Patient Safety Leadership program will include the following courses:

- Foundations of Patient Safety and Quality Care
- Communication and Collaboration
- Organizational Leadership/Health Systems
- Error Science, Risk and Disclosure
- Team Training, Simulation and Principles of Applied Leadership (includes on-site residency)
- Health Sciences Research and Information Technology
- Economics, Policy and Environment
- Creating Human and System Change

A positive change in patient care!

For information, contact Anne Gunderson, program director, at (312) 996-9643 or agunders@uic.edu

More about The Global Campus at http://global.uillinois.edu.

Lunch

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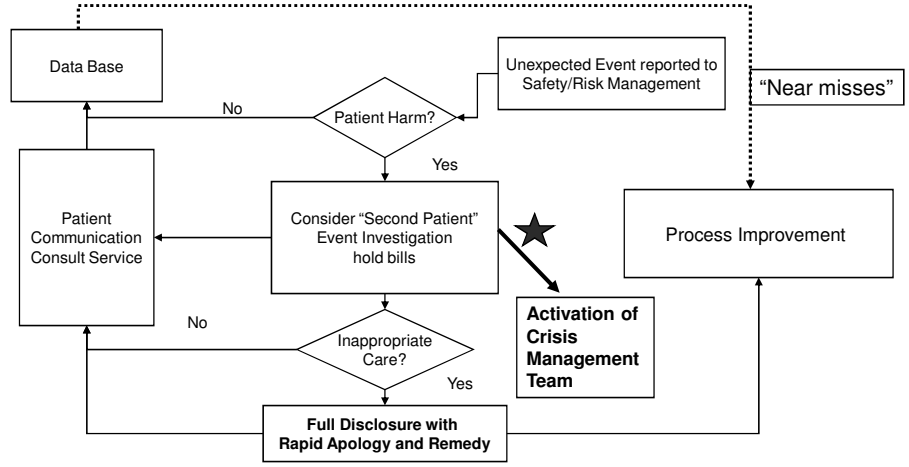

Family Contact

Nikki Centomani
&
Susan Anderson

Family Contact

- 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

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

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

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

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Notifications
AOC
House Manager
Infection Control
IRB (research protocol)
Legal (opinions)
Medical Examiner
Nursing Supervisor/ Manager
OCA
Peds Psych RRT
Privacy
Public Relations
Quality
SGA/RCB
Security
URMO

Equipment
Obtain and Sequester:
Telemetry (Download hx from inpt monitor and/or crash cart)
Equipment and packaging
IV bags
Catheters
Drains
Tube Feedings
etc.…
Call JAZ and Biomed.

Second Victim Support
- Call EAP for non-physician staff
- *HO - Bev Fauman or Tamara Gay?*
- Attendings: Dr. Ken Silk
- Provide Staff support card, next steps etc…
- Call SW (for other pts & visitors, too)
- Spiritual Care

Debrief (Immediately, if possible)
- Invite OCA, Quality, EAP (for staff other than physicians)
- Create list of treaters
- Interview (Standardized questions)

Criminal
(See Protocol)

Customer Service
Customer service recovery (time limited, resources: GAP etc.)

Photographs/Video
Save to RM folder
(See RM Camera Resource Guide)
(KATIE)

Patient Contact
- RM contact pt./family.
- Send a f/u letter after contact.
- Monitor pt. condition & ongoing needs.

Blood/Tissue
Ask for samples. Contact Pathology, sequester relevant specimens. Placenta. Drug analysis.

RM is notified of an event resulting in *permanent* harm, cardiac/respiratory arrest or unexpected death.
- **Ask treaters to stay on-site.**
- **Call 3-5456, give pt. name/reg#, your name and brief description of event.**
- **A pair of Risk Managers will arrive on scene immediately. (The service RMC is preferred as 1 of the 2 RMC's, if not avail, contact SQA for assistance.)**
- **When both RMC's are on scene, a brief timeout for updates and division of labor will occur.**

Disclosure
(Initial and ongoing)
- Disclosure: What/Who?
- Documentation of disclosure
- See Exhibit

Billing
- Write-off vs. hold
- Pt. balance vs insurance
- Future care: Business card w/sticker or letter for Dept. Admin.
- Liens

Documentation
- Provide advice on Medical Record Documentation
- Copy handwritten medical records
- Obtain and sequester:
  - Bed assignment sheets
  - Cath Lab (Program?)
  - Coag records
  - Fetal monitoring strips
  - OR pick list & charges
  - Paging records
  - Pharmacy records
  - Psych records
  - Radiographic images (OSH)
  - Telemetry strips
- Exhibit ? (reference on doc.)

Reviews
- Quality of Care (Internal vs. External)
- Causation/Damages
- End of Life

Claim/ Potential Claim
Refer to Claims Process Flow

PSRF
RL entry and scoring.
OCA memo criteria (preventable deaths & serious injuries, systems issues, JC criteria…)

KEY: Immediate action required.

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Event Response

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

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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SIGNIFICANT CASE INVESTIGATION CHECKLIST

	N/A		
Assess and Triage Event Report	☐	☐	Assess Harm related to the adverse event or the potential to do so
	☐	☐	Present adverse event to RM Director and Chief Safety and Risk Officer for Health Affairs
	☐	☐	Obtain and document approval to proceed with investigation under direction of MSRB
	☐	☐	Activate Crisis Management Team as needed
Sequester Evidence	☐	☐	Secure location of event, i.e. patient room or procedural area
	☐	☐	Secure all equipment/devices-**do not move, turn off, or change equipment or settings**
	☐	☐	Contact Clinical Engineering as required for assistance, on call engineer via NRO
	☐	☐	Secure all disposables, i.e. medication vials, IV bags, catheters, etc.
	☐	☐	Obtain all records: medical record, departmental worksheets, logs (transports), and schedules (OR)
	☐	☐	Identify all individuals noted in the medical record
	☐	☐	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
Initiate Communications	☐	☐	Consider care provider and referrals to EAP and/or Peer Support Program as appropriate
	☐	☐	Prepare strategy for PCCS with key stakeholders and patient/family
	☐	☐	Advise care providers on appropriate medical record documentation post event
	☐	☐	Contact Patient Accounts and/or WWT with billing related requests as needed
	☐	☐	Notify Claims Management
		☐	Place copy of Occurrence Report in binder
Interview Key Individuals	☐	☐	Contact the Unit Director and/or Program Director of each employee to be interviewed
	☐	☐	Schedule interviews of key staff in person
	☐	☐	Determine best physical setting and arrangement for interview
	☐	☐	Review file, documents, notes prior to interview
	☐	☐	Prepare interview strategy, questions, and materials
	☐	☐	Prepare outline of the subject areas to be addressed in logical sequence
	☐	☐	Compose questions in each subject area to assist in further development during interview
	☐	☐	Use medical records and other documents during interview to establish timeline of events
	☐	☐	Gather facts which determine **Duty, Breach, Causation, and Injury**
	☐	☐	Provide "Care for the Care Provider" information as needed
	☐	☐	Provide interviewees with contact information/business card
Ongoing Significant Event Investigation Analysis Process	☐	☐	Present key issues which ascribe **Duty, Breach, Causation, and Injury** to RM Director and Chief Safety and Risk Officer for Health Affairs
	☐	☐	Develop strategy for investigation and identify additional staff to be consulted/interviewed
	☐	☐	Consider application of National Patient Safety Goals and "Never Events"
	☐	☐	Review applicable UMCC policies, procedures, guidelines
	☐	☐	Flow chart process if applicable
	☐	☐	Obtain literature review if applicable
	☐	☐	Enter all applicable information in MIDAS including date and time of determination to proceed with full investigation
		☐	Obtain peer review using Peer Review Worksheet for cases as appropriate
	☐	☐	Advise Patient Care Director/Nursing Manager, monitor patient and ongoing needs
	☐	☐	Maintain contact with Guest Services to serve as Patient Advocate/Liaison

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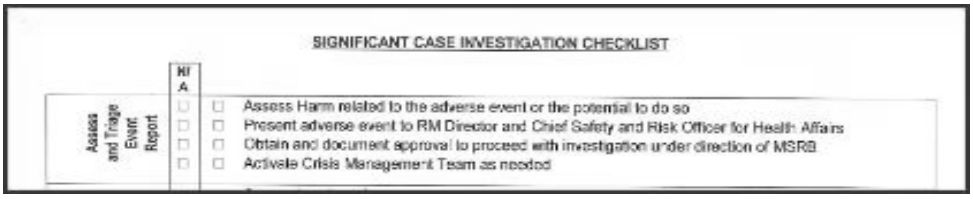

SIGNIFICANT CASE INVESTIGATION CHECKLIST

	N/A		
Assess and Triage Event Report	☐	☐	Assess Harm related to the adverse event or the potential to do so
	☐	☐	Present adverse event to RM Director and Chief Safety and Risk Officer for Health Affairs
	☐	☐	Obtain and document approval to proceed with investigation under direction of MSRB
	☐	☐	Activate Crisis Management Team as needed

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Event Stabilization

- **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

Preserve Information

- 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

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)

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?

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

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

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)

Managing the Financial Impact

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

Operational Process

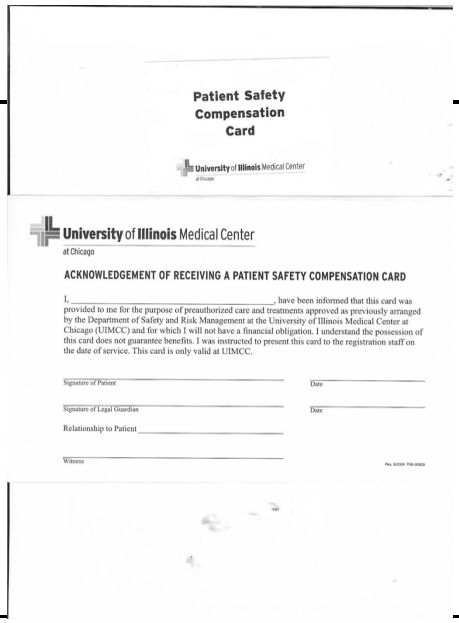
- Future care
- Patient Safety Compensation Card
- Registration alerts
- Patient Safety Hotline

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



Patient Safety Compensation Card

University of Illinois Medical Center at Chicago

ACKNOWLEDGEMENT OF RECEIVING A PATIENT SAFETY COMPENSATION CARD

I, _____, have been informed that this card was provided to me for the purpose of preauthorized care and treatments approved as previously arranged by the Department of Safety and Risk Management at the University of Illinois Medical Center at Chicago (UIMCC) and for which I will not have a financial obligation. I understand the possession of this card does not guarantee benefits. I was instructed to present this card to the registration staff on the date of service. This card is only valid at UIMCC.

Signature of Patient _____ Date _____

Signature of Legal Guardian _____ Date _____

Relationship to Patient _____

Witness _____

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How many disclosures?

- To self
- To peer
- To colleague
- To other caregivers
- To the "system"
- To patient and/or family

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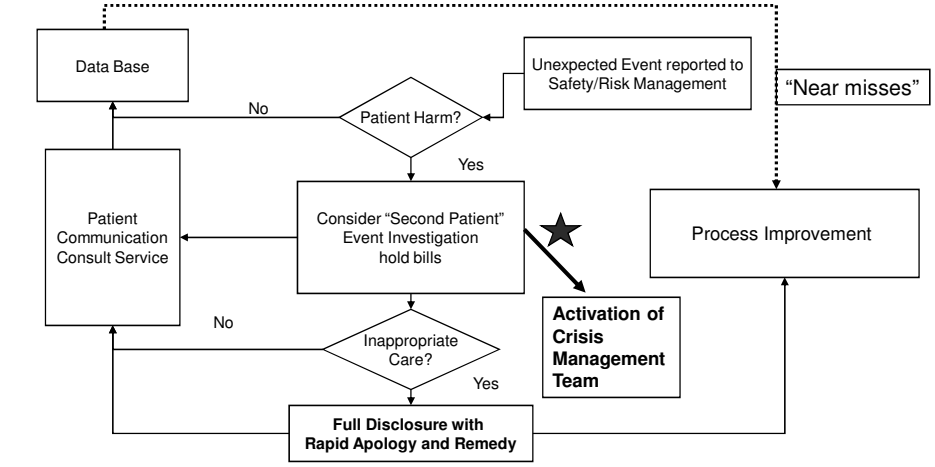
Comprehensive Approach to Adverse Patient Events



Disclosure is a process: not an event

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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

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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

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Patient interviewed by her own attorney after disclosure and settlement

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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.

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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.

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

Health systems and care givers gain a tremendous advantage when they approach compensation honestly

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Compensation resources

- **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."

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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**

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Anticipate stereotypes and urban legends and dispel them

Don't expect audience to understand your business

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*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

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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

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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

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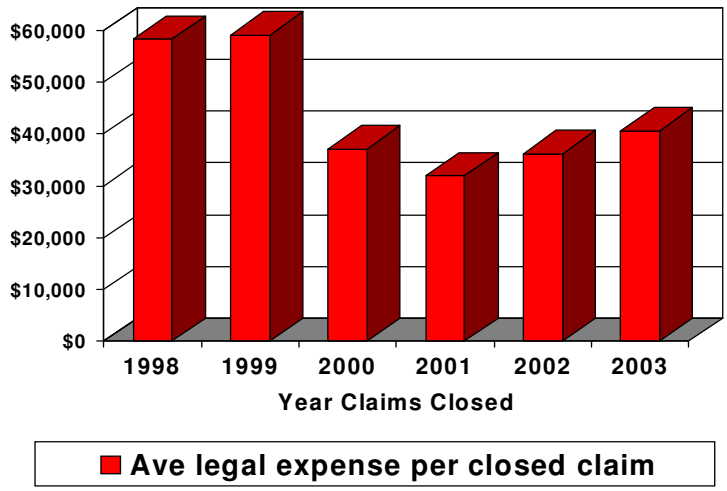
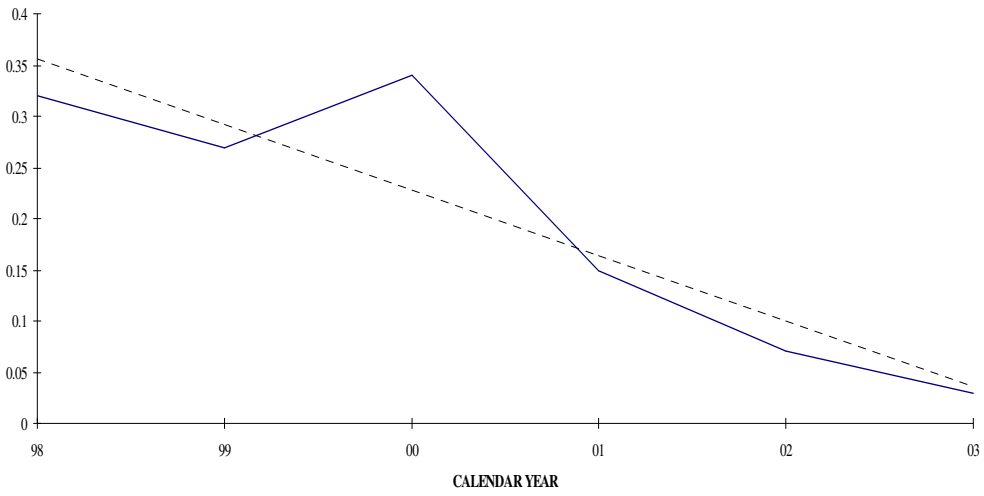
Legal Expense Paid



THE UNIVERSITY OF MICHIGAN
SELF-INSURED MEDICAL PROFESSIONAL LIABILITY PROGRAM
TOTAL OUTSIDE LEGAL PAID/INDEMNITY PAID



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UMHS Average Transaction Expense*

- **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**

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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**

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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

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- Compare actual results against settlement authority extended
- Compare actual results against Case Evaluation assessments

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Other Performance Measures

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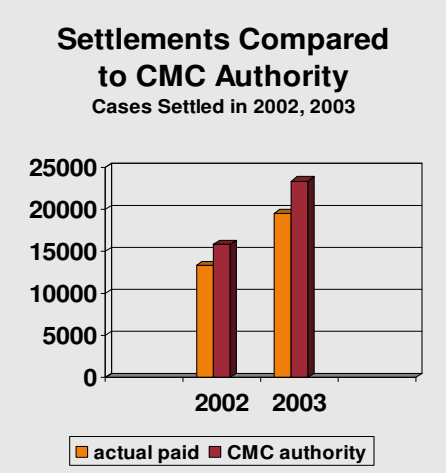

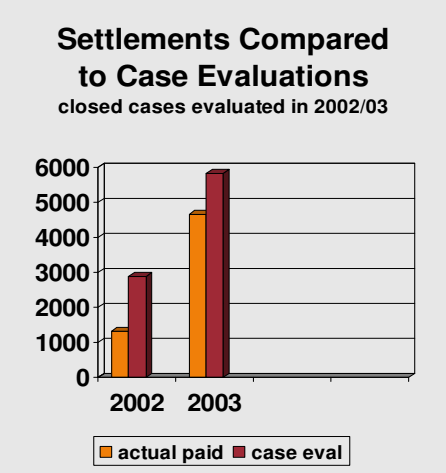

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Other comparisons

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- **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.

Hoeft, 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

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Continue to focus on long range gains while you're finding your way in the short run

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Work hard to publicize your story

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- **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**

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Confront costs directly and sell the value

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

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Put numbers in context

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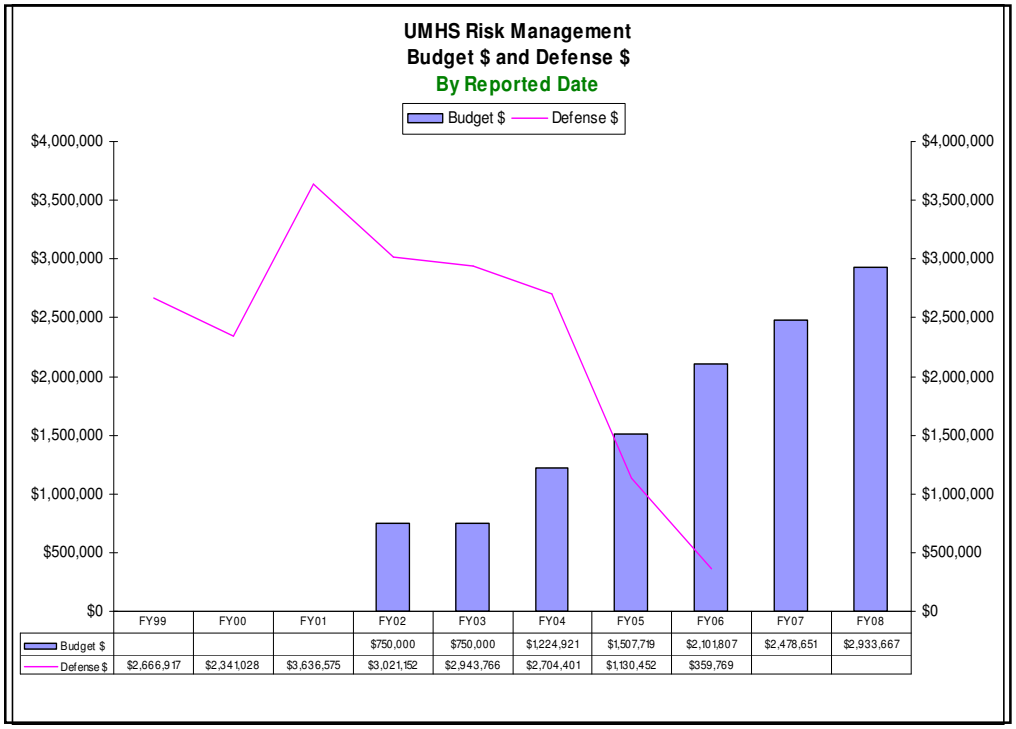

	FY99	FY00	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08
Budget $				$750,000	$750,000	$1,224,921	$1,507,719	$2,101,807	$2,478,651	$2,933,667
Defense $	$2,666,917	$2,341,028	$3,636,575	$3,021,152	$2,943,766	$2,704,401	$1,130,452	$359,769		

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Money is better spent in Risk Management than with outside counsel

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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**

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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

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Evolution of the RM Budget 2002 – 2007

- **Claims histories**
  - 2002: 604 2006: 1,127
- **Events reported**
  - 2002: 3,891 2006: 13,989
- **Educational programs**
  - 2002: 48 2006: 205
- **RM Rounds**
  - 2002: 26 2006: 40
- **Privacy investigations**
  - 2002: 0 2006: 54
- **Calls to main line**
  - 2002: N/A 2005: 13,015 2007: 23,944
- **Difficult patient terminations: 250 – 300 annually**
- **Employees 2002: 9 2006: 17 2009: 26**

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Evolution of the RM Budget 2002 – 2007

- **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**

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Evolution of the RM Budget 2002 – 2007

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- **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

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Demonstrate responsibility and accountability

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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**

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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

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Truthfully, it's not about claims, apologies, law suits at all.

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Collateral Benefits

Clinical Improvements

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Clinical Improvements Derived Directly from Claims

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- **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"**

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Collateral Benefits

Faculty satisfaction and retention

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UMHS Medical Faculty Attitude toward UMHS Claims Approach

- **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

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Physician productivity

- **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**

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ACTUARIES – Understand the species

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Actuaries

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- **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**

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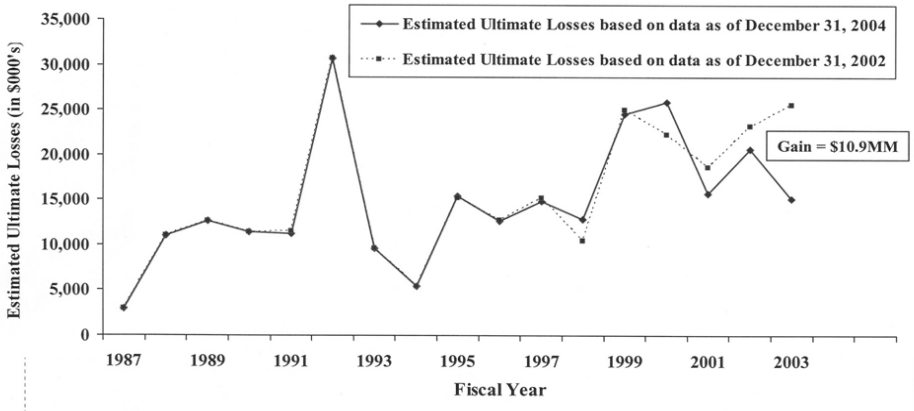
THE UNIVERSITY OF MICHIGAN
VERITAS BOARD MEETING

MEDICAL PROFESSIONAL LIABILITY
Comparison of Ultimate Losses



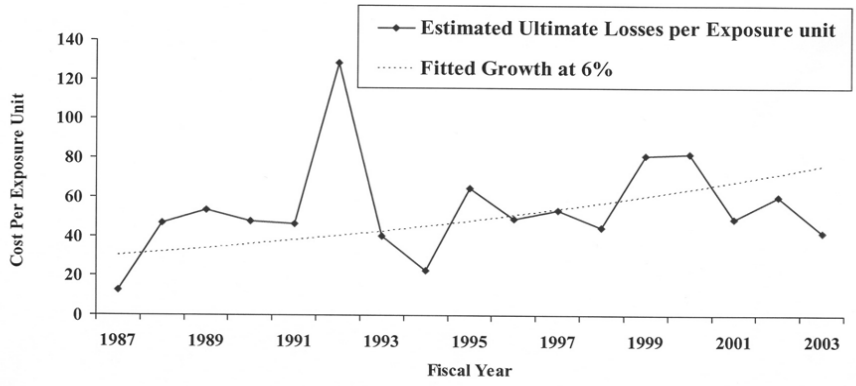
[1] Based on University of Michigan data.

DION, DURRELL + ASSOCIATES INC.
Actuaries and Consultants

Graph 3A

THE UNIVERSITY OF MICHIGAN
VERITAS BOARD MEETING

MEDICAL PROFESSIONAL LIABILITY
Estimated Ultimate Losses per Exposure Unit



[1] Based on University of Michigan data.

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Graph 3B

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Take home message: control the message

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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.

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Need to undo stereotypes

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Need to step backwards to core values, then think creatively

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Barriers

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- **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**

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The very best risk management is to make no medical mistakes

"Deny and defend" and learning from mistakes are mutually exclusive

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UM Claims Management Model
1985-2002

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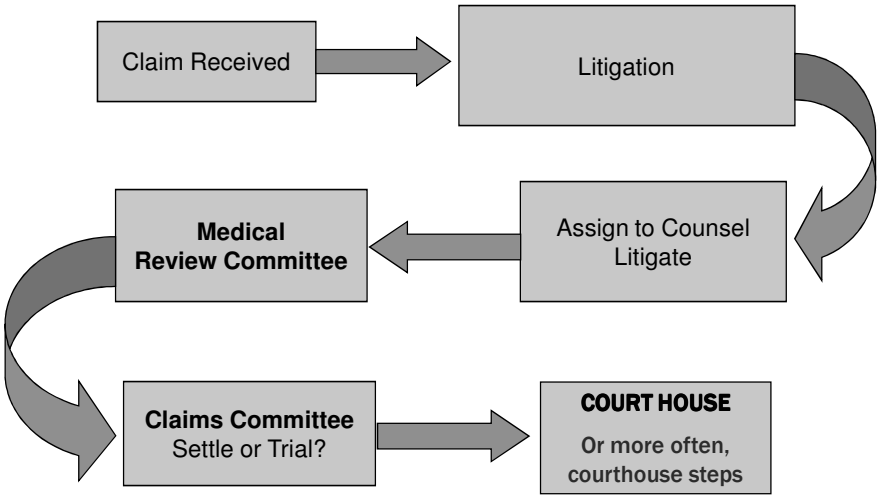

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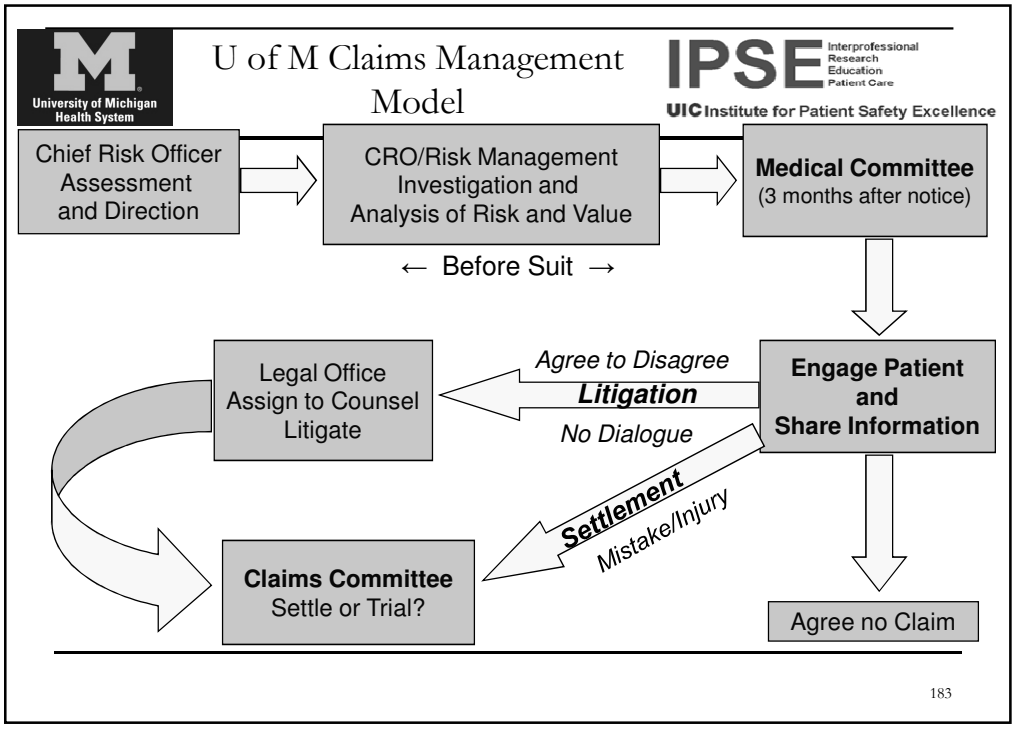
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U of M Claims Management Model
IPSE Interprofessional Research Education Patient Care
UIC Institute for Patient Safety Excellence
Chief Risk Officer Assessment and Direction
CRO/Risk Management Investigation and Analysis of Risk and Value
Medical Committee (3 months after notice)
← Before Suit →
Legal Office Assign to Counsel Litigate
Agree to Disagree
Litigation
No Dialogue
Engage Patient and Share Information
Settlement
Mistake/Injury
Claims Committee Settle or Trial?
Agree no Claim
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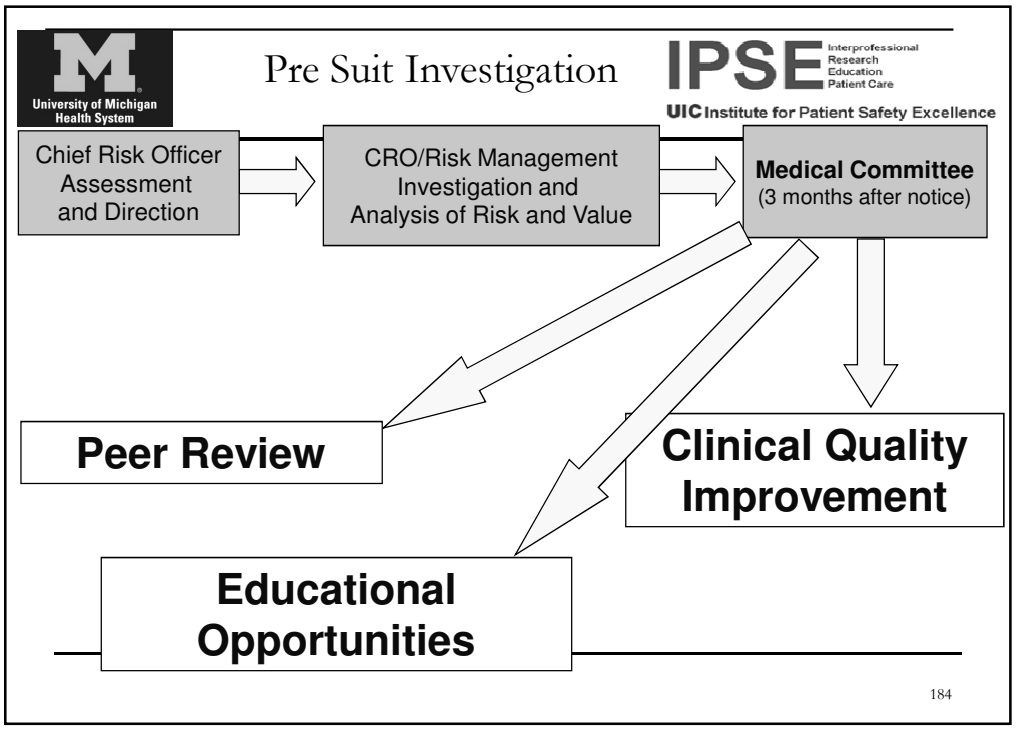
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Pre Suit Investigation
IPSE Interprofessional Research Education Patient Care
UIC Institute for Patient Safety Excellence
Chief Risk Officer Assessment and Direction
CRO/Risk Management Investigation and Analysis of Risk and Value
Medical Committee (3 months after notice)
Peer Review
Clinical Quality Improvement
Educational Opportunities
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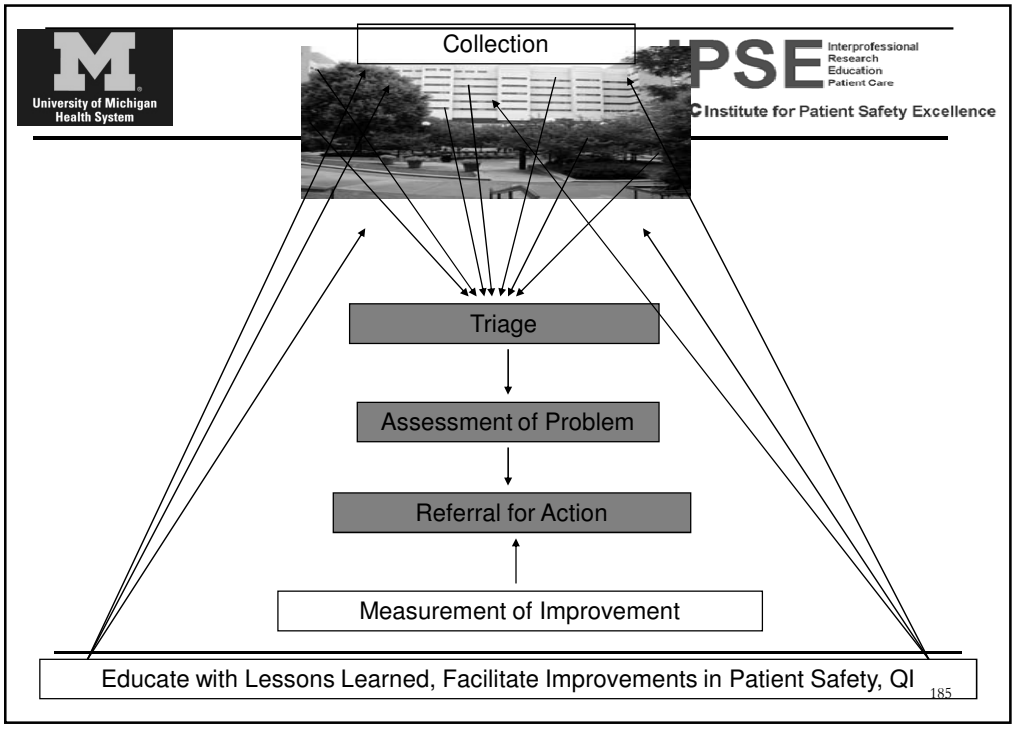
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Collection
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Triage
Assessment of Problem
Referral for Action
Measurement of Improvement
Educate with Lessons Learned, Facilitate Improvements in Patient Safety, QI
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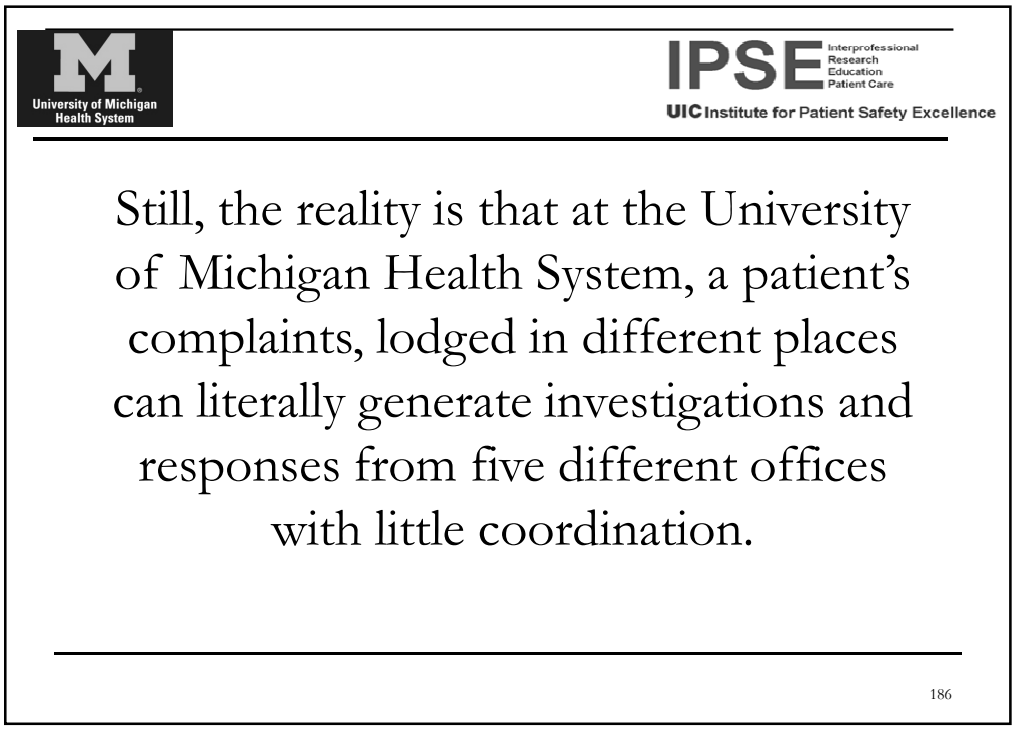
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Still, the reality is that at the University of Michigan Health System, a patient's complaints, lodged in different places can literally generate investigations and responses from five different offices with little coordination.
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Peer Review

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Plastic surgeon

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Had claims and complaints from surgeries:

7/3/90	10/28/00
10/16/92	11/16/01
9/3/93	01/11/02
5/23/97	5/10/02
6/30/97	10/4/02
8/13/97	5/2/03
3/21/98	6/30/03
6/26/98	7/18/03
7/24/98	2/6/04
3/15/99	

Maternal-Fetal specialist

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Claims History

1/8/91
9/8/92
4/14/94
12/9/94
10/15/98

Heart Attack – November, 1999

4/07/00
5/26/00
8/20/01

- Two brain damaged babies
- One brain damaged mom
- $6.6 million dollars
- Three devastated families
- One devastated doctor

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The problem of old lions . . .

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- **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**

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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**

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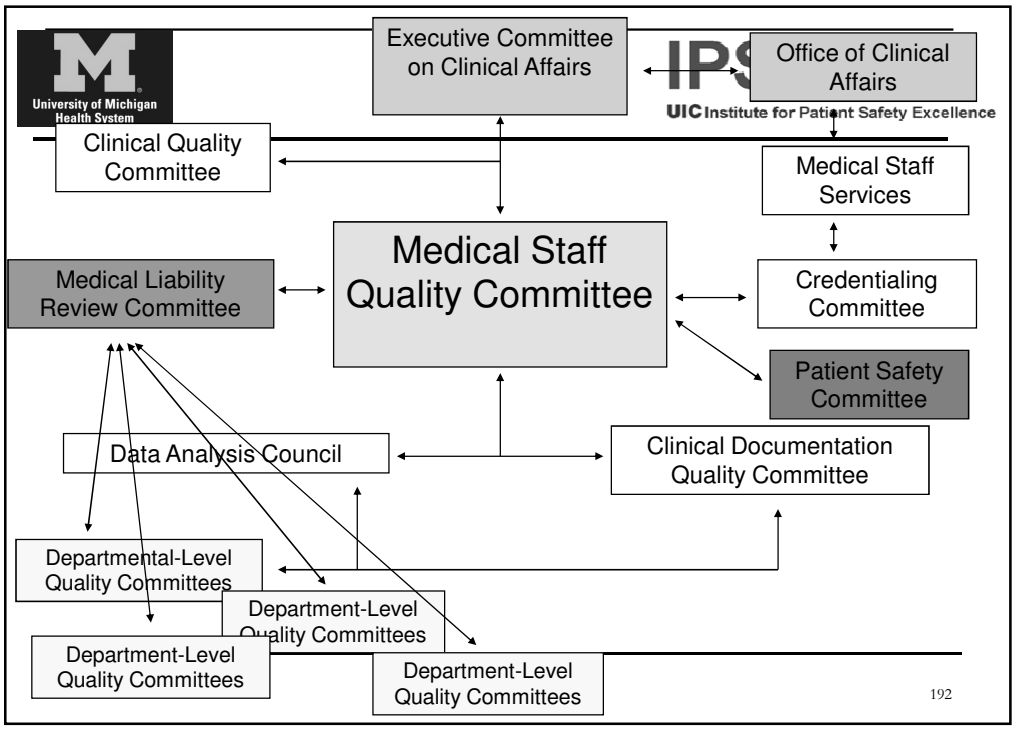

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- **Extreme Honesty: the principled approach to adverse events.**
- **Linking to the National Quality Forum Safe Practices**

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Why we do this……

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- **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

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