Shifting Paradigms

Identifying and Responding to Healthcare Related Harms

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Full Disclosure

- I have received research funding to develop and evaluate programs that connect early communication of medical errors (Patient Safety Incidents) with patient safety outcomes in the United States.
- The work I have led to date, uses the U.S. health system as its laboratory and case study.
- The information that I am sharing today, is from the perspective of the U.S. medical-legal system and my experience improving patient safety within that system in partnership with patients.

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

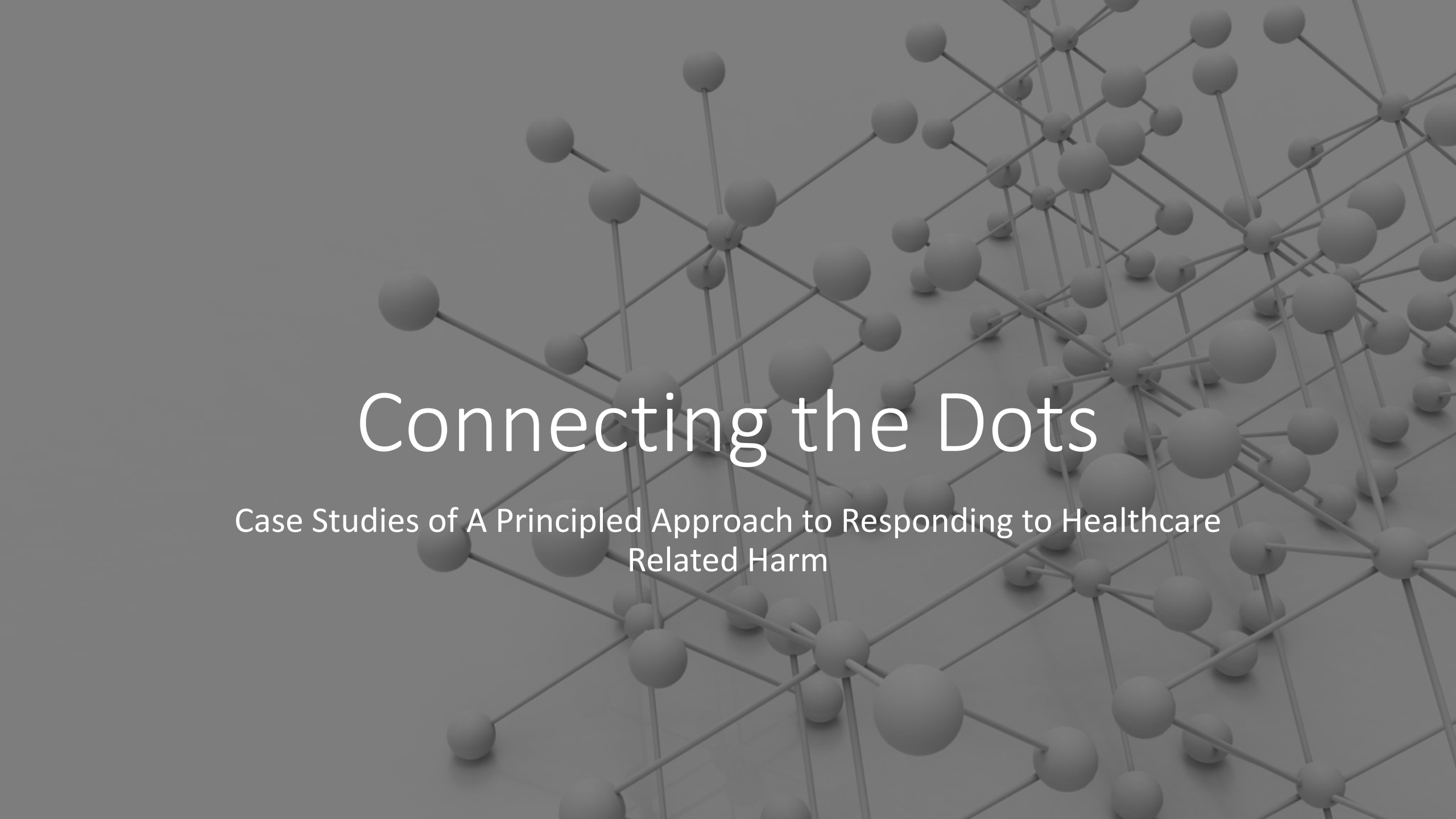
Lucien Leape

Why a Communication & Resolution Program?

Patient Safety Incidents continue to cause harm

Costs of medical liability continue to escalate globally

CRP can restore trust and retain relationships

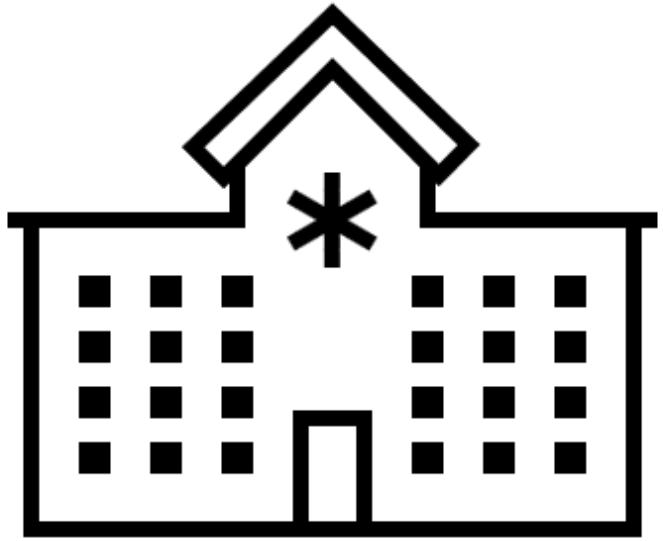


Connecting the Dots

Case Studies of A Principled Approach to Responding to Healthcare Related Harm

Case Study #1:
Urban Hospital in Chicago, Illinois

- 450 bed tertiary care academic medical center
- 20,000 discharges/year
- 900,000 outpatient visits/year
- 50% of patients uninsured or public aid
- Employed medical staff
- Only State-run hospital remaining in Illinois



1. Lambert BL, Centomani NM, Smith KM, Helmchen LA, Bhaumik DK, Jalundhwala YJ, McDonald TB. The "Seven Pillars" Response to Patient Safety Incidents: Effects on Medical Liability Processes and Outcomes. Health Serv Res. 2016 Dec;51 Suppl 3(Suppl 3):2491-2515. doi: 10.1111/1475-6773.12548. Epub 2016 Aug 24. PMID: 27558861; PMCID: PMC5134341.

Goals of the Seven Pillars

Improve patient-provider communication

Improve patient safety by learning from our mistakes, ensuring timely and equitable resolution when patients are harmed

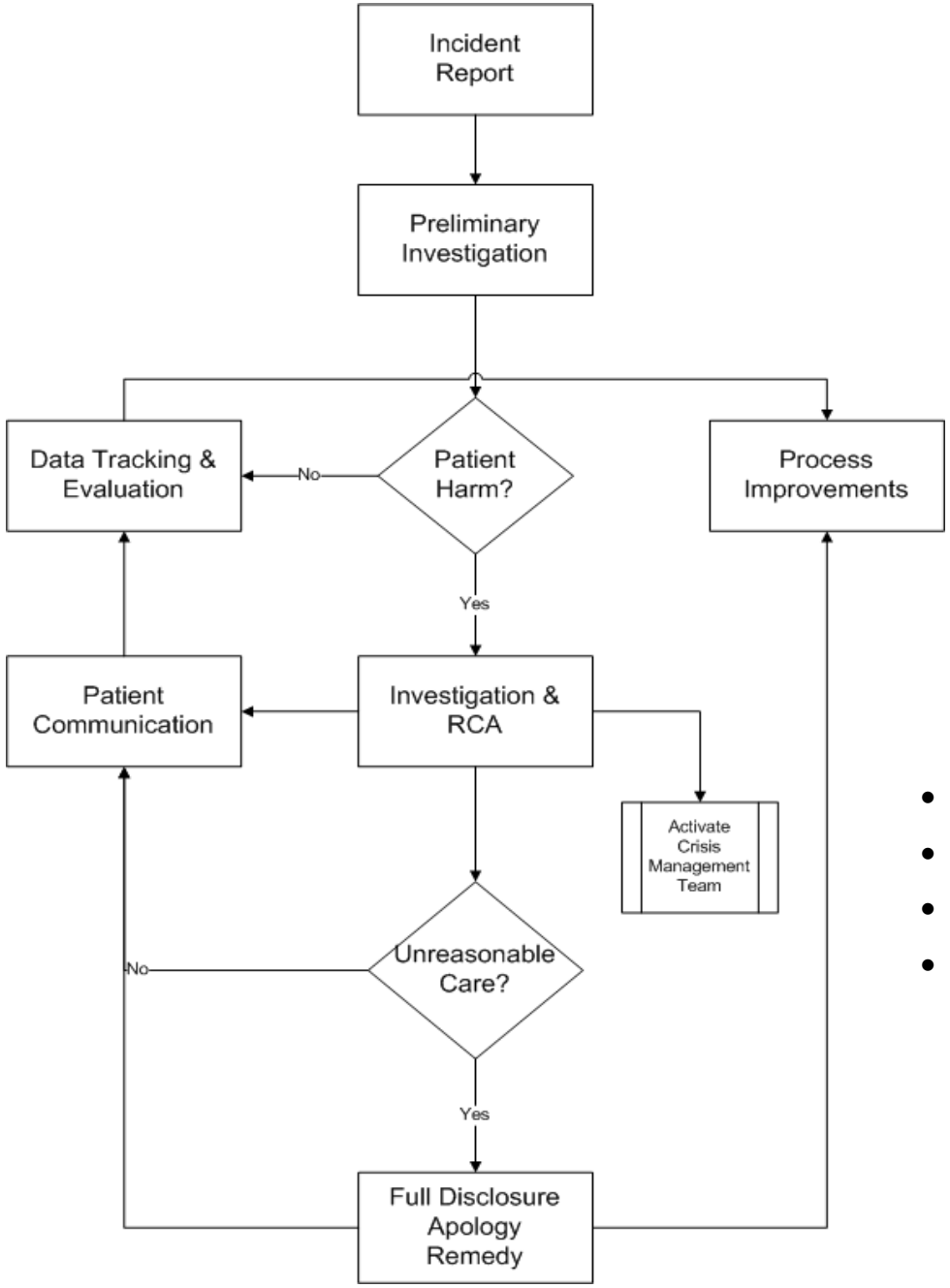
Reducing frivolous lawsuits by adopting a policy of transparency, honesty, and full disclosure

Reducing medical liability and malpractice premiums

Seven Pillars Guiding Principles

- Provide effective open and honest communication to patients and families following patient harm
- Apologize and provide rapid resolution when inappropriate or unreasonable medical care causes harm; Vigorously defend appropriate care
- Learn from mistakes
- Reckless behavior subject to corrective action
- Provide support for clinicians and staff involved in patient safety incidents

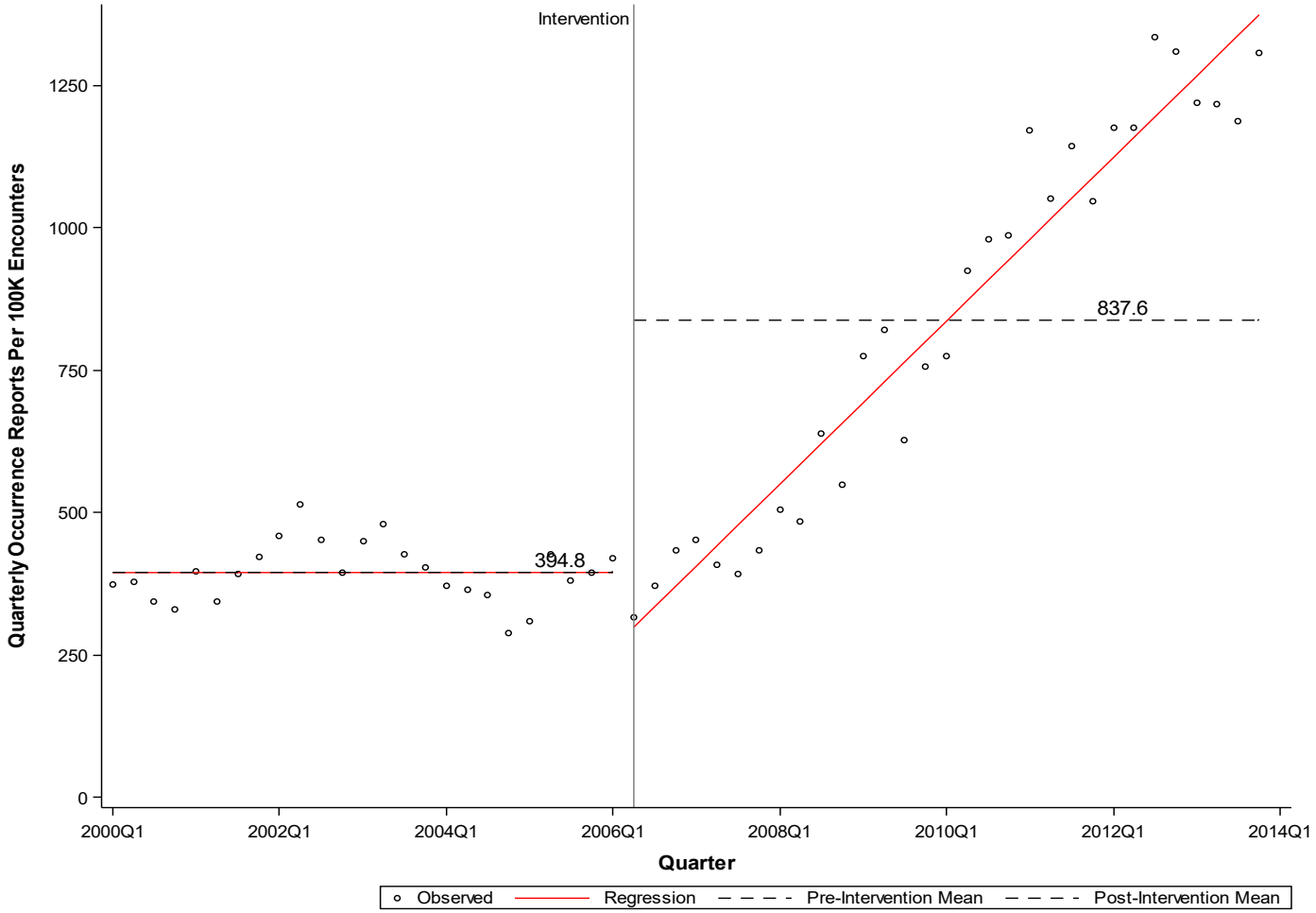
Seven Pillars Process



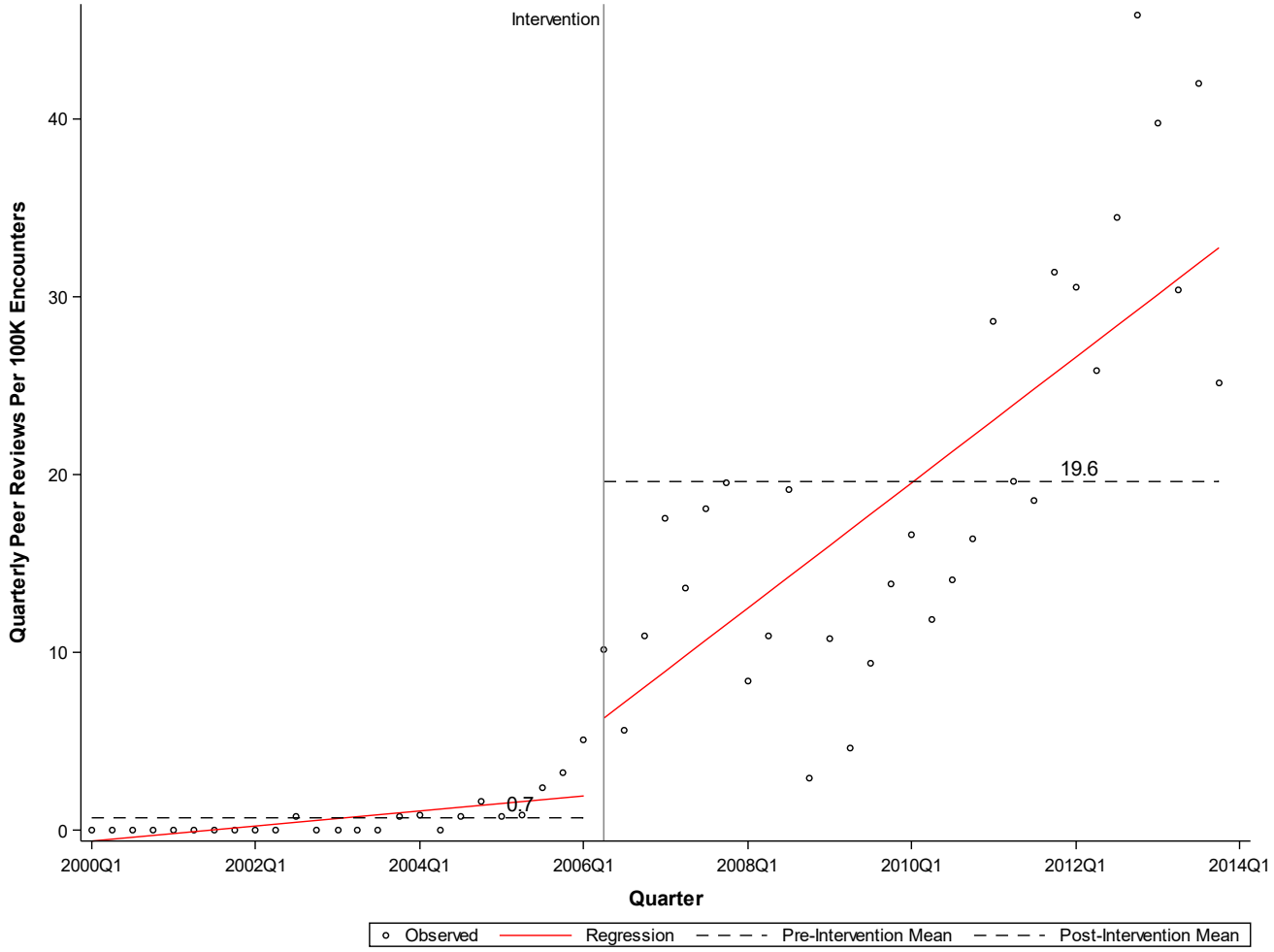
Crisis Management

- *Care for the Caregiver*
- Risk Management & Legal
- Leadership Team
- Occupational Health

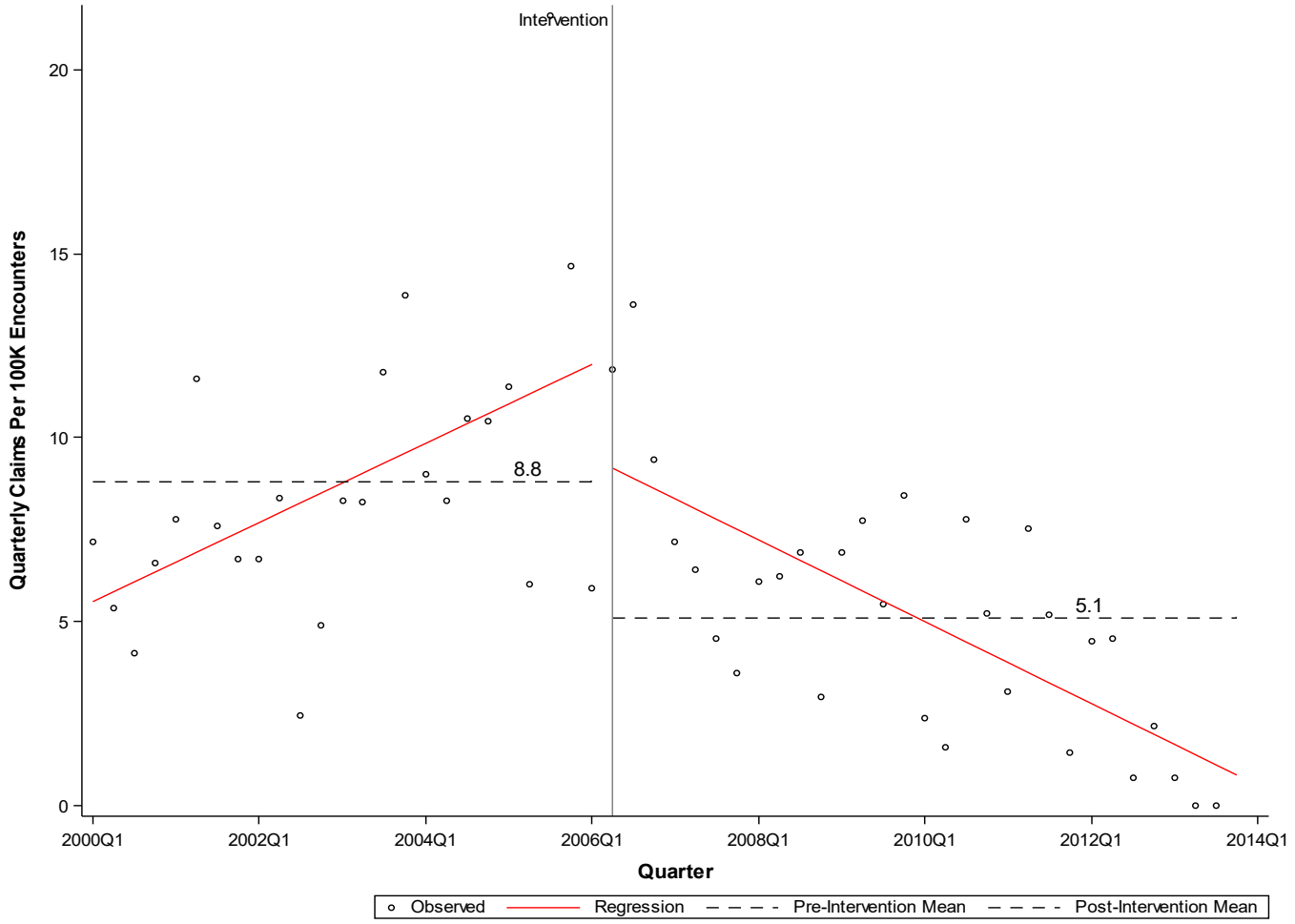
Event Reporting



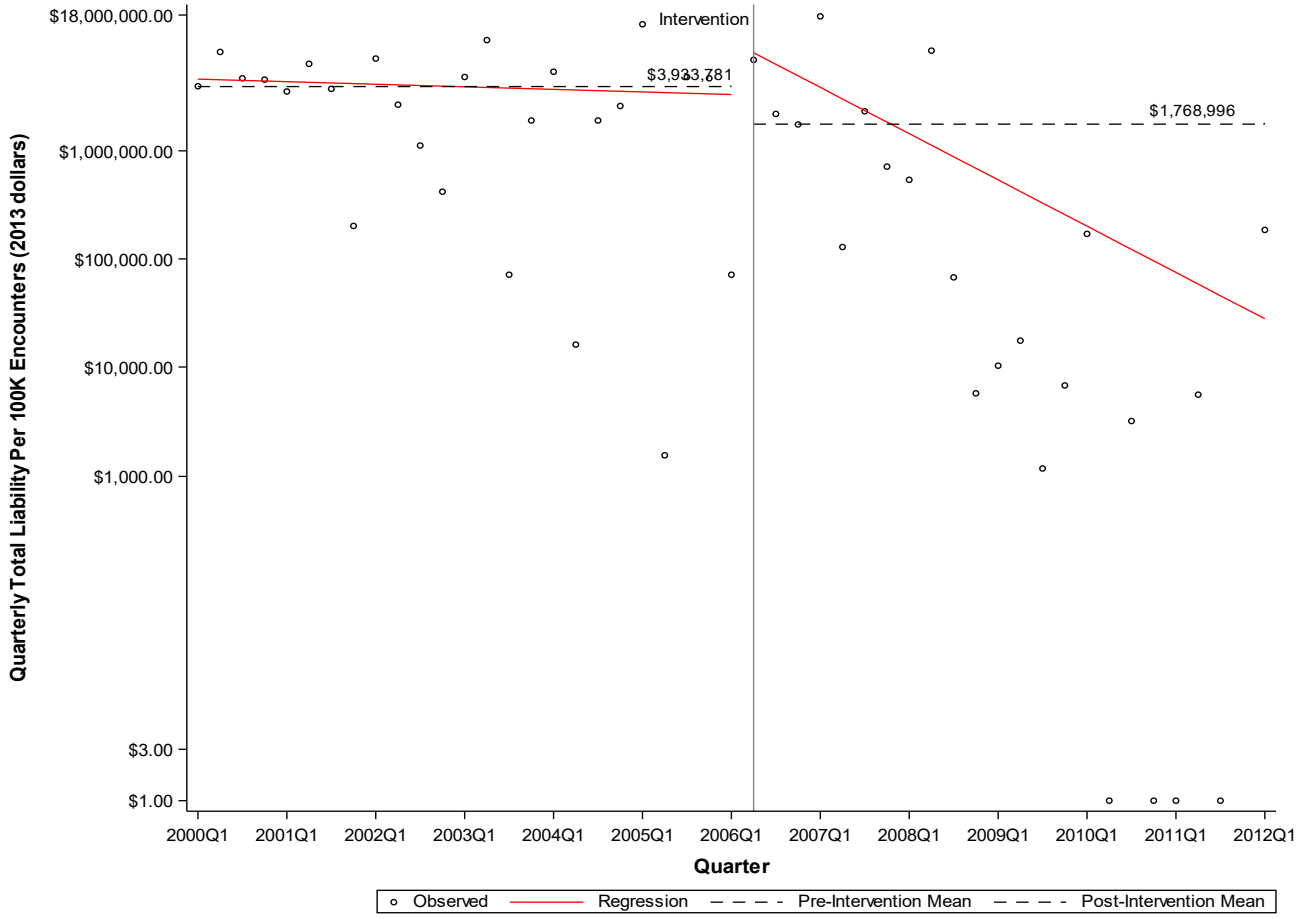
Peer Reviews



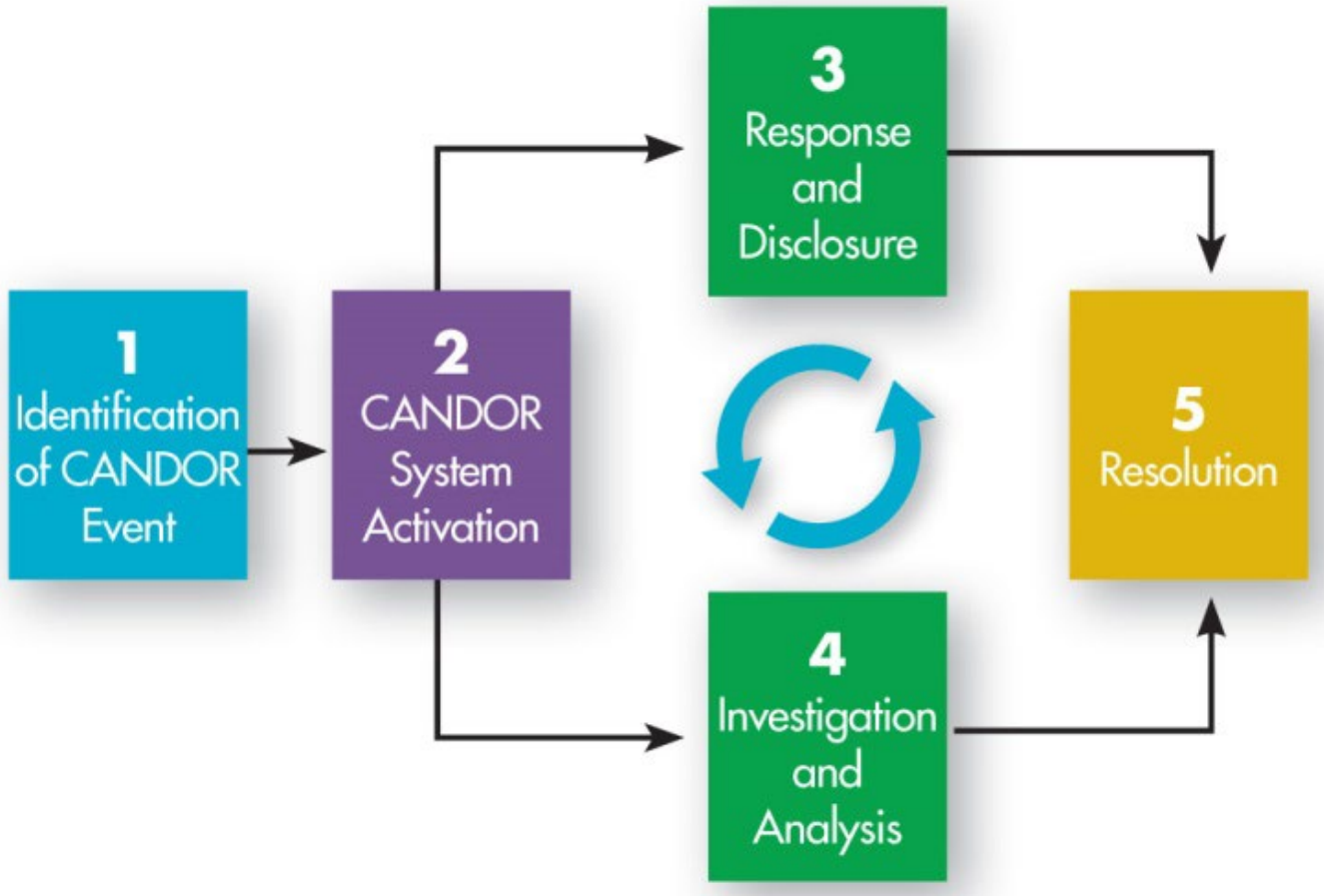
Claims


Intervention
20
15
10
5
0
Quarterly Claims Per 100K Encounters
8.8
5.1
2000Q1
2002Q1
2004Q1
2006Q1
2008Q1
2010Q1
2012Q1
2014Q1
Quarter
Observed
Regression
Pre-Intervention Mean
Post-Intervention Mean

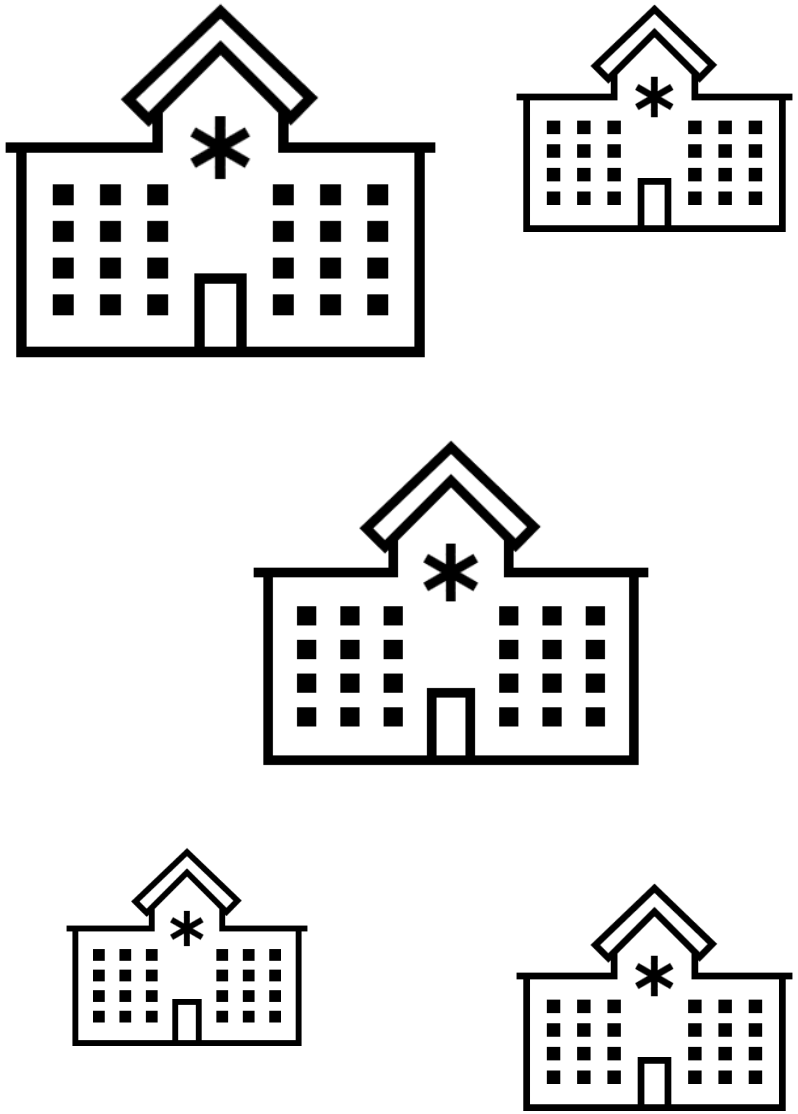
Quarterly Total Liability Costs



CANDOR – Communication & Optimal Resolution



Case Study #2:
10 Hospital System in Eastern U.S.



- Mix of urban & rural hospitals
- Some large academic; others small critical access hospitals
- ~300 ambulatory care sites across 4 states
- 36,000 staff and clinicians
- Commitment to High Reliability Organization
- Mix of employed and contract physicians
- Adapted model of the Seven Pillars-CANDOR

CANDOR - Comprehensive Patient Safety Program

- Immediate Response to Patient Harm - “Go Team”
  - State of the Art Event Review
  - Immediate Patient/Family Communication
  - Care for the Caregiver
- Created a Legal Collaborative to discuss CANDOR case response

https://www.ahrq.gov/news/newsroom/case-studies/201712.html
Smith KM, Smith LL, (Jack) Gentry JC, Mayer DB. Lessons learned from implementing a principled approach to resolution following patient harm. Journal of Patient Safety and Risk Management. 2019;24(2):83-89. doi:10.1177/2516043518813814

Case Study Impact

- 74% Decrease in Serious Safety Events post-implementation
- $40M savings in medical liability costs within the first 3-years
- Significant improvements in safety culture
  - Largest improvement was in “Non-punitive response to error”
- Reporting increased from 2,200/year to 35,000/year

Lessons Learned

Communication & Resolution Programs

Take Home Messages

- This work is hard – but worth the effort and time to deconstruct systemic barriers to change.
- Caring for our Caregivers – in a cascade of kindness – is an essential ingredient for change to sustain
- Patients need and want to trust us – it is our job to re-establish trust in the wake of harm; and it is possible to do it
- Most successful organizations have reinvested savings into safety program
- Our silos & institutional/role responsibilities are barriers to change

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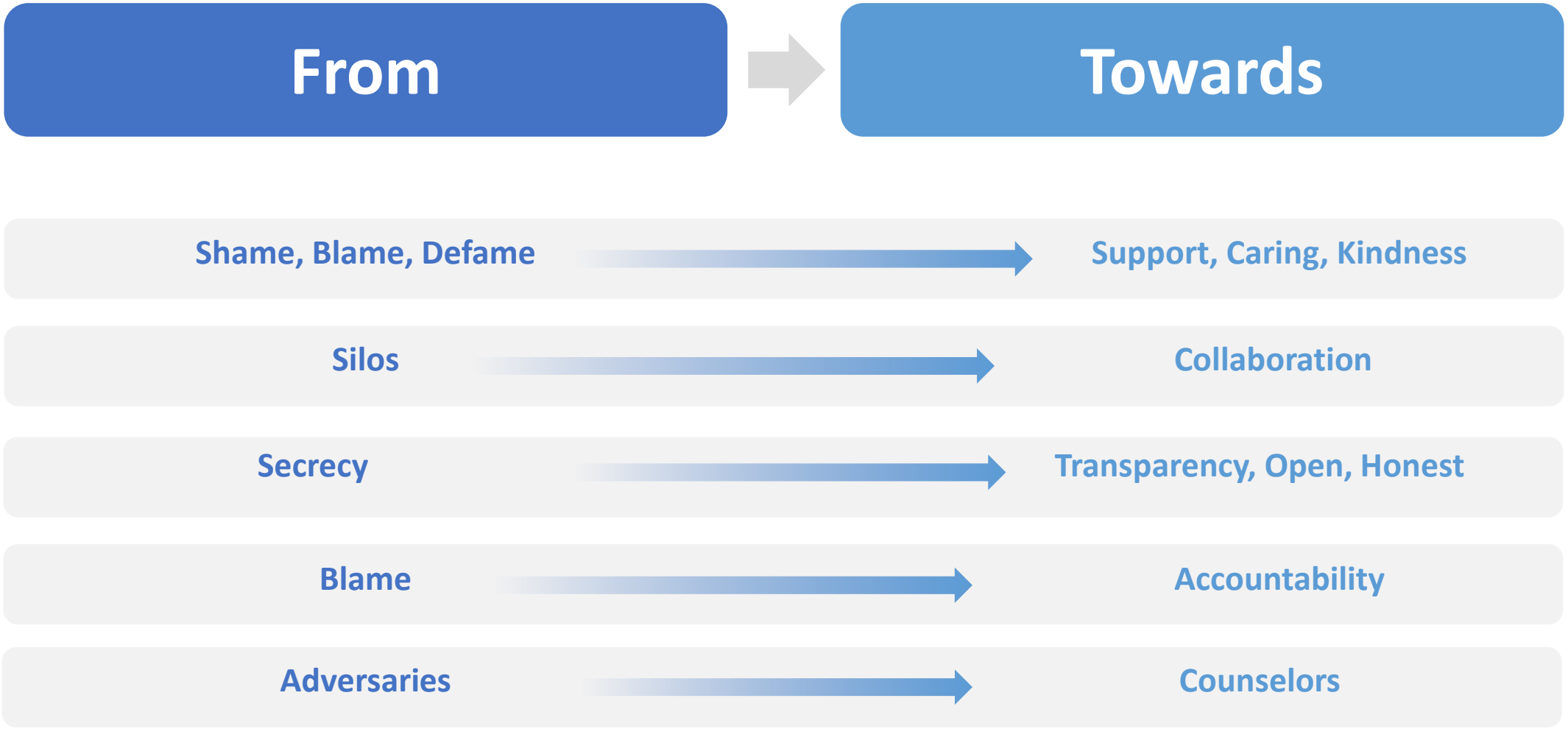
From
Towards
Shame, Blame, Defame
Support, Caring, Kindness
Silos
Collaboration
Secrecy
Transparency, Open, Honest
Blame
Accountability
Adversaries
Counselors

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4. Helmchen LA, Lambert BL, McDonald TB. Changes in Physician Practice Patterns after Implementation of a Communication-and-Resolution Program. Health Serv Res. 2016 Dec;51 Suppl 3(Suppl 3):2516-2536. doi: 10.1111/1475-6773.12610. PMID: 27892622; PMCID: PMC5134359.
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7. Smith KM, Smith LL, (Jack) Gentry JC, Mayer DB. Lessons learned from implementing a principled approach to resolution following patient harm. Journal of Patient Safety and Risk Management. 2019;24(2):83-89. doi:10.1177/2516043518813814
8. https://www.ahrq.gov/news/newsroom/case-studies/index.html?f%5B0%5D=field_case_study_product%3A14147&search_api_views_fulltext=candor

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Improving Diagnostic Safety Capacity. AHRQ ACTION III. HHSP233201500022I.

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Patients Improving Research in Diagnosis. PCORI: 6156-SIDM.

Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families. AHRQ ACTION III. HHSP233201500022I/HSSP2 3337002T

Detecting, Addressing and Learning from Patient Perceived Breakdowns in Care – We Want to Know. AHRQ 4R18HS022757-03.

Medical Liability and Communication Resolution Program Educational Toolkit. AHRQ ACTION II. HHSA2902010000251.

The Seven Pillars: Crossing the Patient Safety-Medical Liability Chasm. AHRQ 1R18HS019565.

A Workshop to Transform Mindsets. AHRQ: 1R13 HS19082.

Diagnostic Safety from the Patient's Perspective. A prioritization Exercise. The Gordon and Betty Moore Foundation, 2019-2021