The Value of Disclosure

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Disclosure

I have nothing to disclose or any conflicts of interest

Objectives

1. To understand the value of disclosure to the patient and to caregivers
2. To review the literature on the impact of disclosure
3. To describe Christiana Care Health System's model, journey, process and outcome metrics

We Serve Together

guided by our values
Excellence & Love

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EXCELLENCE

We commit to being exceptional today and even better tomorrow.

We seek new knowledge, ask for feedback, and are open to change.

We use resources wisely and effectively.

We are curious and continuously look for ways to innovate.

We are true to our word and follow through on our commitments.

LOVE

We anticipate the needs of others and help with compassion and generosity.

We embrace diversity and show respect to everyone.

We listen actively, seek to understand, and assume good intentions.

We tell the truth with courage and empathy.

We accept responsibility for our attitudes and actions.

Can We Talk?

"We would love to set the record straight from all the misinformation that's out there,….Unfortunately, our lips are sealed."

Dr. Daniel J. Adler – works at Yorkville Endoscopy where Joan Rivers had surgery and arrested

What Leads to Litigation?

"Many of those who sue doctors…have no place to hand their grief when that grief and seemingly their loved one's life is being ignored, even declared, in the space left by silence, a thing of no value."

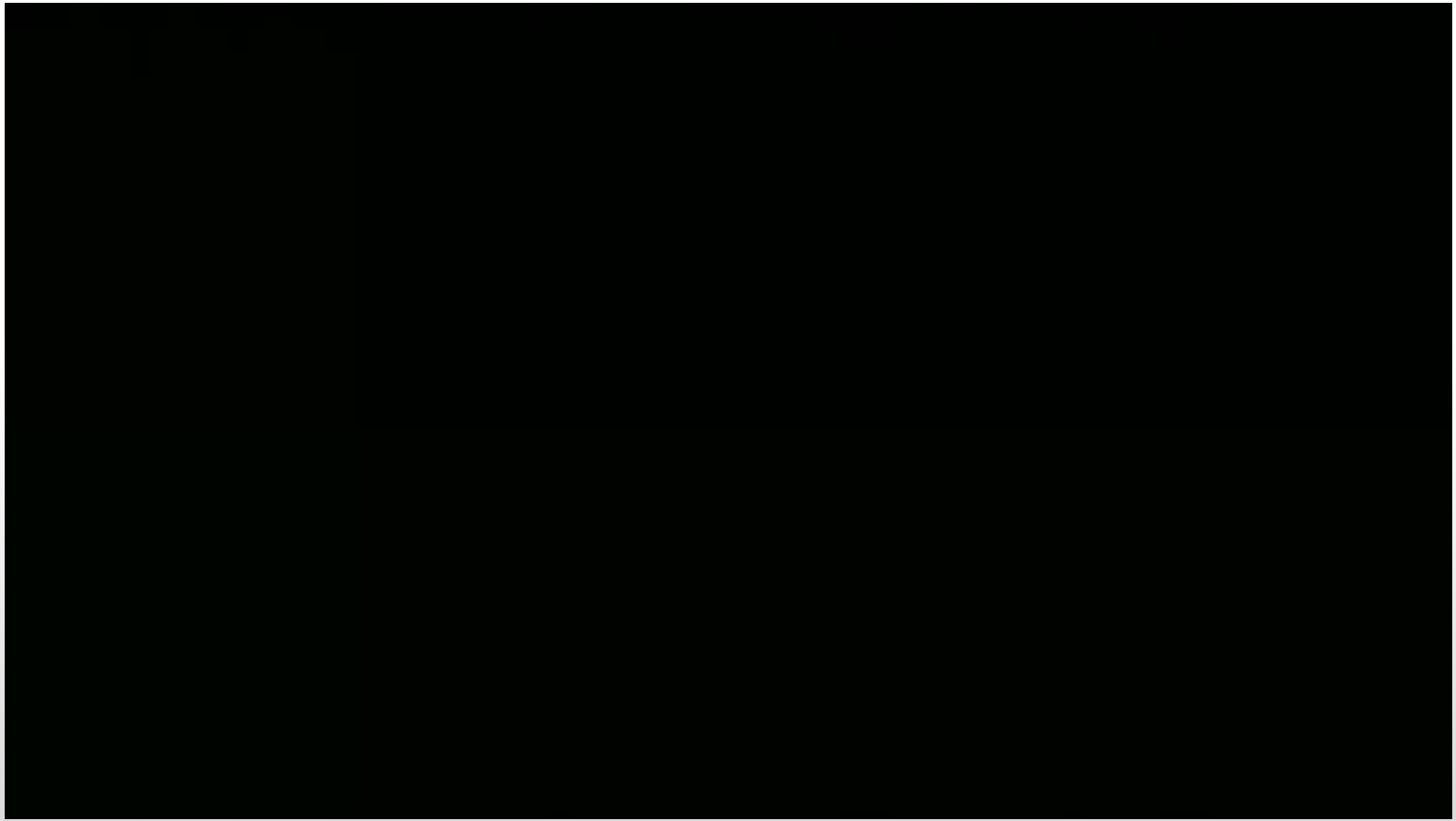
Michael Rowe

Sociologist at Yale

Essay about his son's death

After 2 liver transplants

Patient and Family Perspective



Medicine is Changing

- From a deny/defend mentality to a more transparent way of communicating about safety events
- This new approach requires new skills
- Aligns with Christiana Care's Values and Behaviors

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Disclosure of Medical Errors

Supported by many organizations including American Society of Healthcare Risk Management, National Patient Safety Foundation and the Joint Commission

JC Statement: "Patients and when appropriate their families are informed about the outcomes of care, treatment, and services that have been provided including unanticipated outcomes."

Benefits

- Supports 'culture of safety'
- Respects patients right to be informed
- Strengthens the patient/provider relationship

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Barriers to Disclosure

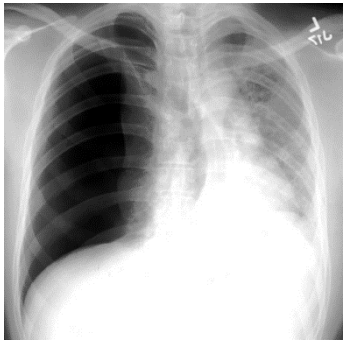
Views/Beliefs

- Not important
- Provider did not contribute to error
- Error had little effect on outcome
- Lack of legal protection
- Lack of clear definition as to what events warrant disclosure

Fears

- Physical retaliation
- Being criticized by colleagues
- Not being able to communicate effectively
- Causing anger
- Unable to handle patient's emotions
- Litigation

Case #1



A radiologist is reading a chest film and determines there is a right sided pneumothorax. As she is dictating the report a colleague overhears her saying that the pneumothorax is on the left. She corrects her colleague who then corrects the dictation before the report is sent out.

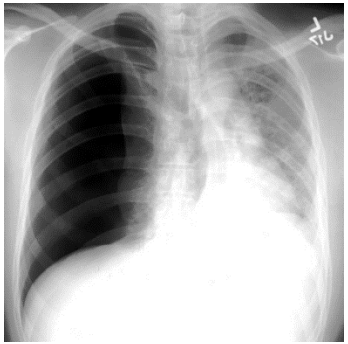
Case 1 - Would you disclose this event?

A. Yes

B. No

C. Not sure

Case # 2



Same case as before except this time the colleague is not there. The report is sent out saying that the pneumothorax is on the left. A nurse taking care of the patient questions the reading since the patient has decreased breath sounds on the right. She calls the radiologist who corrects the dictation before any care it rendered to treat the pneumothorax.

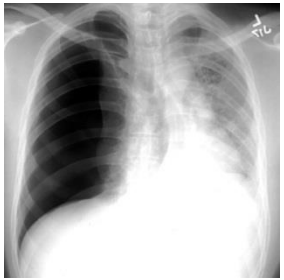
Case 2 - Would you disclose this event?

A. Yes

B. No

C. Not sure

Case #3



Same as the prior case except this time the nurse does not pick up the error. A surgical resident sees the report and places a chest tube on the left side. The patient is stable. The post procedure Xray shows a persistent pneumothorax on the right. The resident looks at the previous film and realizes the report was incorrect. He removes the left chest tube and places one on the right.

Case 3 - Would you disclose this event?

A. Yes

B. No

C. Not sure

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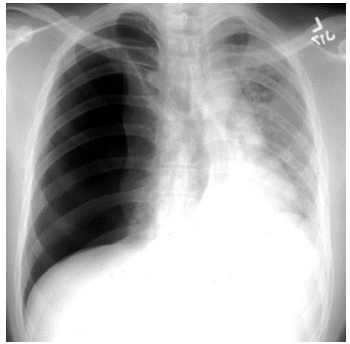
Case #4



Same case as before except while placing the chest tube on the left, the patient develops a hemothorax and has a cardiac arrest. The resuscitation is successful but the patient suffers hypoxic brain damage as a result of the event.

Case 4 - Would you disclose this event?

A. Yes

B. No

C. Not sure

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Literature Overview

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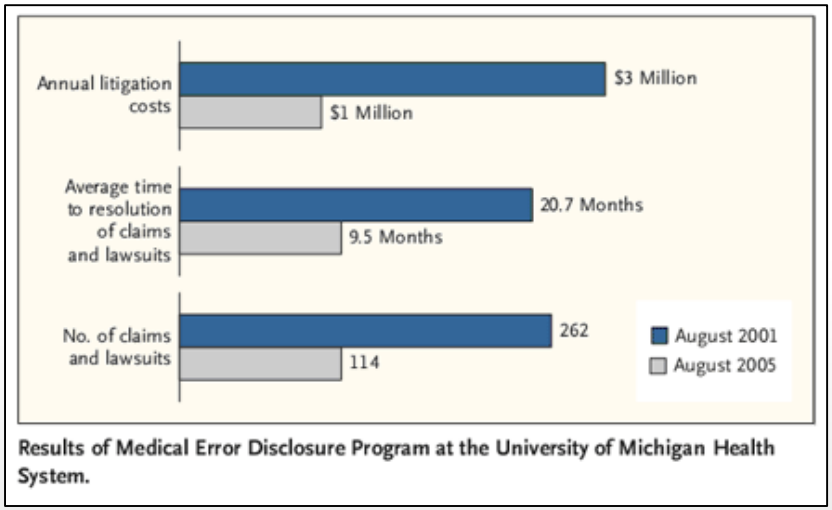
Guiding Principles (UIMCC)

- “We will seek to provide effective and honest communication to patients and families following patient safety incidents involving patient harm.”
- “We will apologize and provide rapid compensation when inappropriate or unreasonable medical care causes patient harm and defend vigorously care that we believe was appropriate.”
- “We will learn from our mistakes.”
- “Reckless behavior will be subject to corrective action.”
- “We will provide support services for providers involved in patient safety incidents.”

Disclosure – Effect on Litigation

- **Imperative to involve legal counsel and liability insurer**
- **University of Michigan Disclosure**
  - "Apologize and learn when we're wrong, explain and vigorously defend when we're right, and view court as a last resort"
  - Claims dropped from 262 in 2001 to 114/year, saved $2 million in legal costs the first year (focuses on selectively trying court cases)



Results of Medical Error Disclosure Program at the University of Michigan Health System.

University of Illinois at Chicago Outcomes

	PRE	POST	
Quality incident reports	479.3	872.5	p<0.0001
Patient communication consults	0.5	12.0	p<0.0001
Peer review	1.4	16	p<0.0001
Claims	8.2	4.2	p<0.0001
Legal expenses	212,820	105,149	p<0.05
Legal fees	255,098	124,281	p<0.05
Cost per claim	278,980	124,281	p<0.05
Settlement amounts	3,461,321	2,055,675	p<0.05

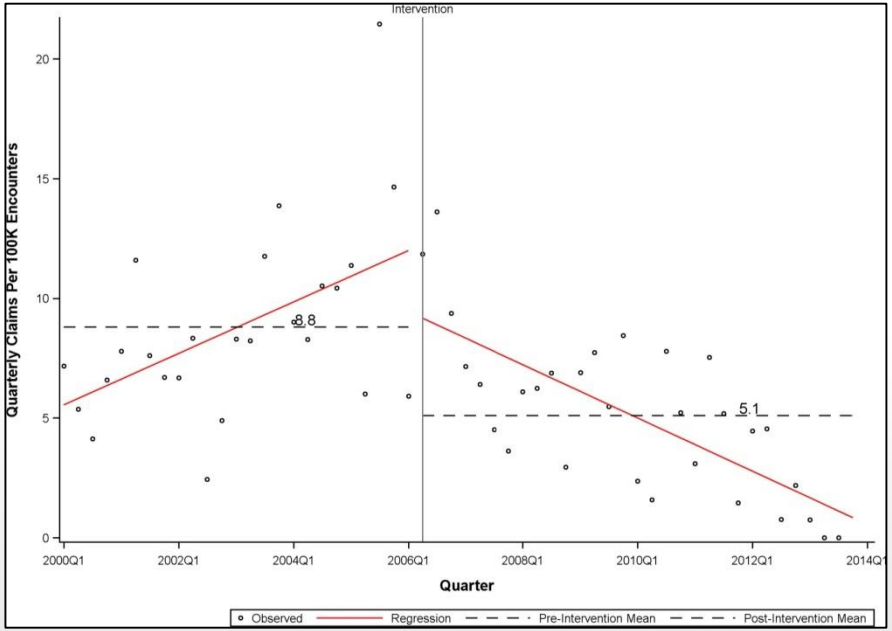
University of Illinois at Chicago
Lambert et al. Health Services Res 2016

Study Showed:

- **Increased reporting**
- **Increased event analysis**
- **Decreased claims**
- **Decreased legal fees**
- **Decreased cost per claim**
- **Decreased settlement costs**
- **Decreased self insurance costs**

Clinically and financially significant

Effects persisted 7 years after initial intervention



Quarterly Claims per 100,000 Encounters at UIH, 2000–2014

Interrupted Time Series used;
Mann Whitney U and segmented regression models

University of Illinois at Chicago
Lambert et al. Health Services Res 2016

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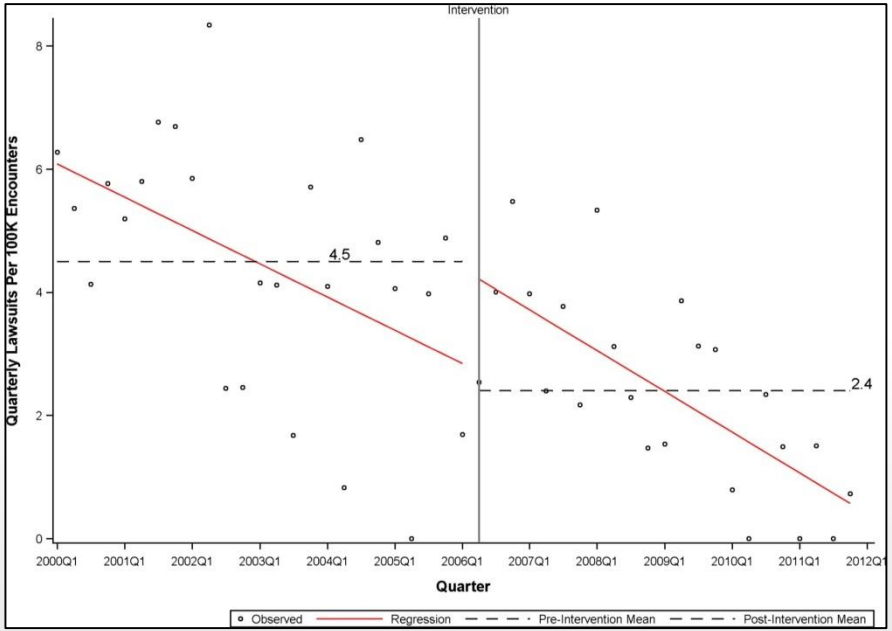

Quarterly Lawsuits per 100,000 Encounters at UIH, 2000–2011

Interrupted Time Series used;
Mann Whitney U and segmented regression models

Mello et al. Health Affairs 2017

Outcomes from 2 Massachusetts Hospital Systems

Satisfaction with CARe program reported on 184 surveys from clinicians involved in CARe events:

“Overall, how supportive are you using the CARe process to try to resolved unanticipated care outcomes?”	69.4% Strongly Positive
“Overall, how fairly did program representatives treat the patient or family?”	70.0% Strongly Positive
“Overall, how fairly were you treated in the CARe process?”	64.3% Strongly Positive

Moore et al. 2017 JAMA Internal Medicine

Conducted at Stanford, Baystate and Beth Israel (Boston)

- "What meant something to us was people, like the resident, who actually cared….He wrote [my daughter] a letter and came to visit her….He wasn't afraid to actually reach out….That meant something to us, more than an apology." - Family Member
- "The doctor listened and let me talk and talk and talk. I almost cried because it was the first time anyone had heard how I felt. He talked when I was done. It changed how I felt about the hospital." – Patient
- "The attending should be in the room, no matter how upset he is. I'm not half as upset as the patient or the family. This isn't about me…." - Physician

Value to Providers

- Able to discuss more openly
- Helps to avoid the ‘Second Victim’ phenomenon
- Allows for peer support

The Second Victim

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

The Second Victim

Leads to:

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

Commonly Heard Phrases

"This event shook me to my core."

"This has been a turning point in my career."

"It just keeps replaying over and over in my mind."

"I'm going to check out my options as a Walmart greeter. I can't mess that up."

"I'll never be the same."

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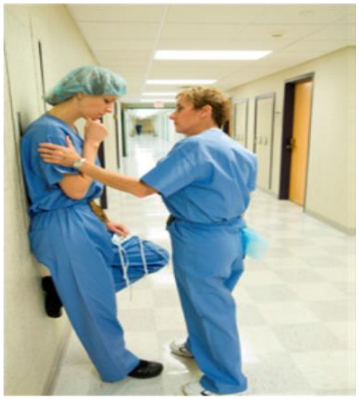
Current State

- 92% of surveyed physicians have been involved in a medical error (57% serious)
- 90% felt that their hospital did not adequately support them in coping with medical error-associated stress
- One in seven staff reported experiencing a patient safety event in the past year that caused personal problems (e.g., anxiety, depression)
- 30-50% of health professionals may be considered second victims after an AE

Commonly Reported Symptoms

- Extreme fatigue
- Sleep disturbances
- Memory/concentration impairment
- Headaches, Muscle tension
- Irritability
- Emotional numbing
- Decreased job satisfaction
- Flashbacks
- Loss of confidence
- Grief/remorse

Behavioral Changes



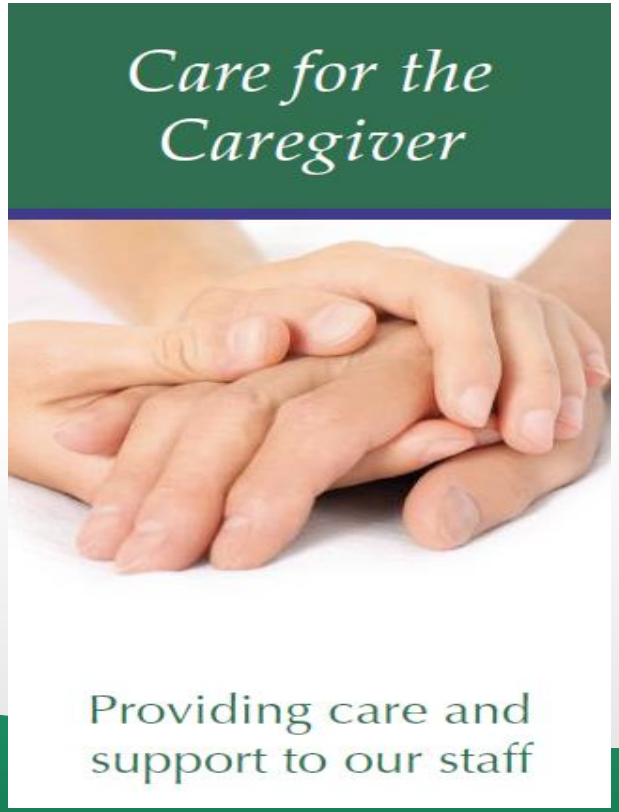
Change in activity level

Change in appetite

Drug or alcohol abuse

Social withdrawal

Christiana Care: Care for the Caregiver



CARE FOR THE CAREGIVER

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Care for the Caregiver

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

- **700+ activations to date**

Caring for our Own

"A large portion of the health care workforce has been suffering in relative silence unsupported during career-related anxiety, stress, and sometimes even shame or guilt…it is our moral imperative to design and deploy a readily accessible and effective support infrastructure for all health care providers."

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Institutional Requirements for Disclosure

- Integrate disclosure, patient safety and risk management
- Establish disclosure support system
- Provide background education
- Ensure coaching available
- Provide emotional support
- Use PI tools to track and enhance disclosure

Project CANDOR

- An AHRQ Demonstration Project
- Three Hospital Systems participating

Background to CANDOR

- **2005:** University of Illinois at Chicago creates communication-resolution program to confront medical malpractice crisis
- **2009:** President Obama direct AHRQ to develop grant
- **2013** AHRQ grant: “Seven Pillars”, 10 self-insured, private hospitals with open medical staffs
- **2013** Comprehensive Patient Safety/Medical Liability Communication and Resolution Program **Educational Toolkit:** Connect medical liability to patient safety and quality, originally 4 demonstration hospitals

What is a CANDOR Event?

- **Adverse Event** – A patient safety event that resulted in harm to the patient
- **CANDOR Event** – An adverse event that resulted in permanent harm or death

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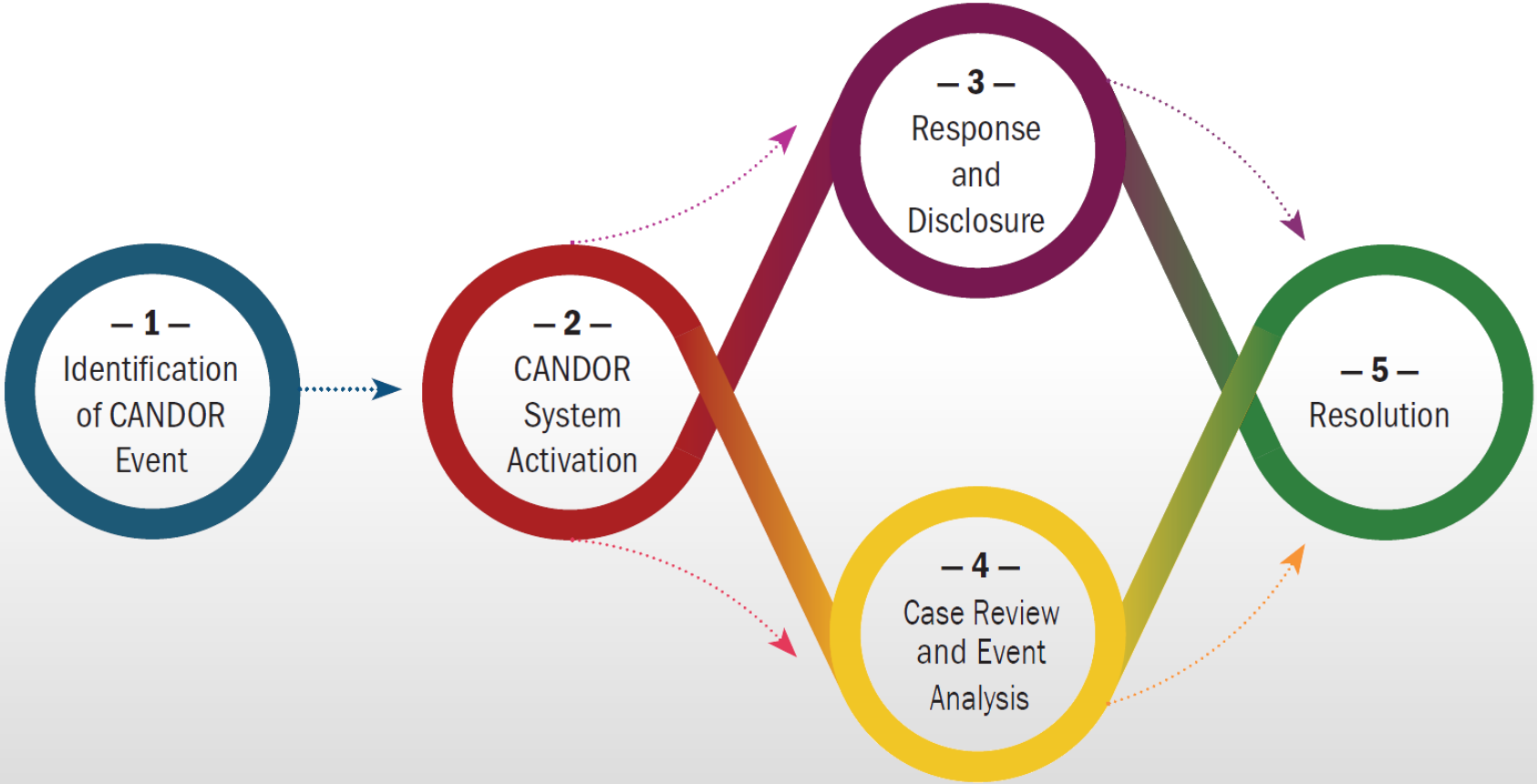
CANDOR Approach & Process



Our Metrics

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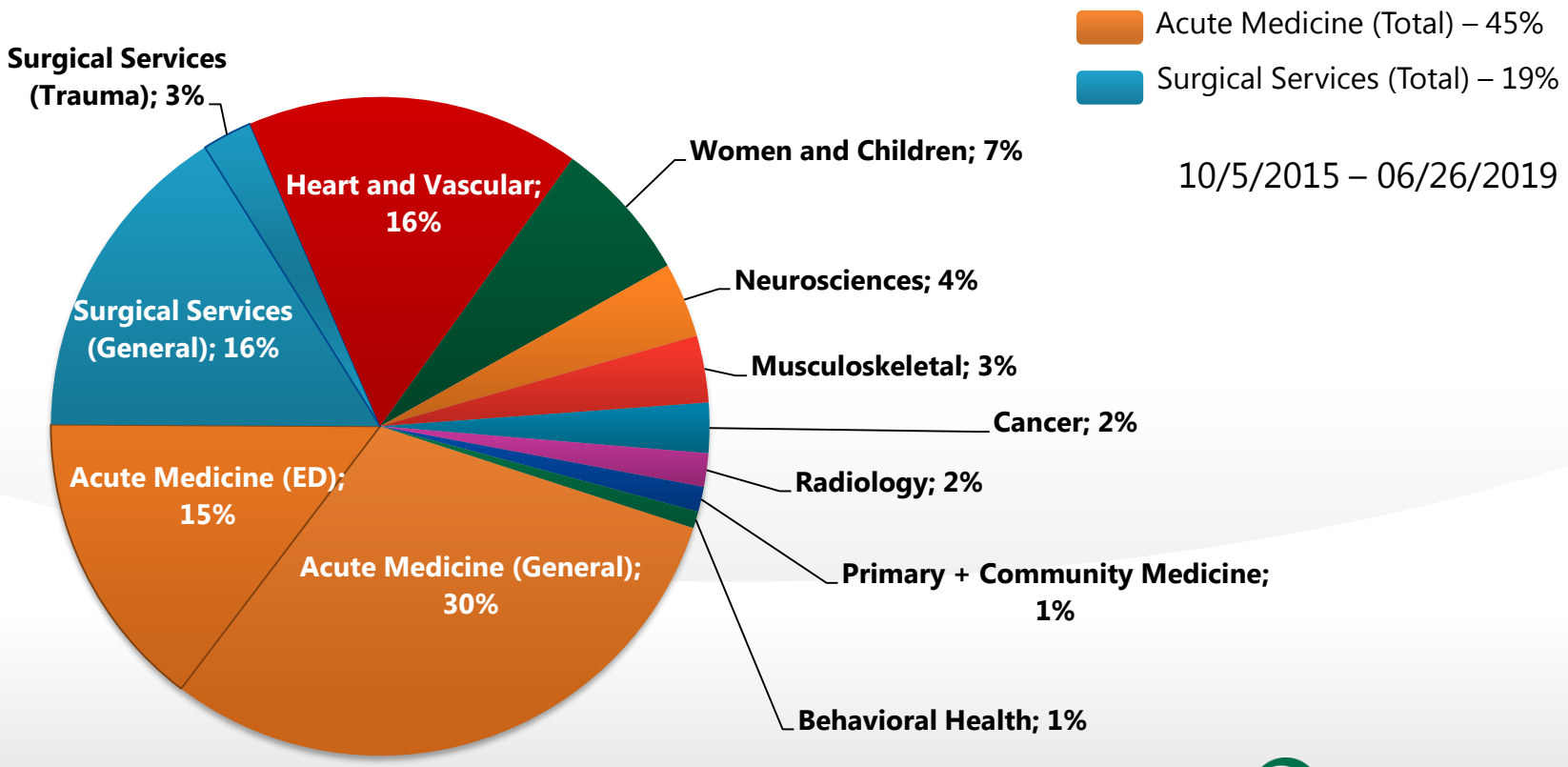
CANDOR Alerts by Service Line



CANDOR Alerts

n=244

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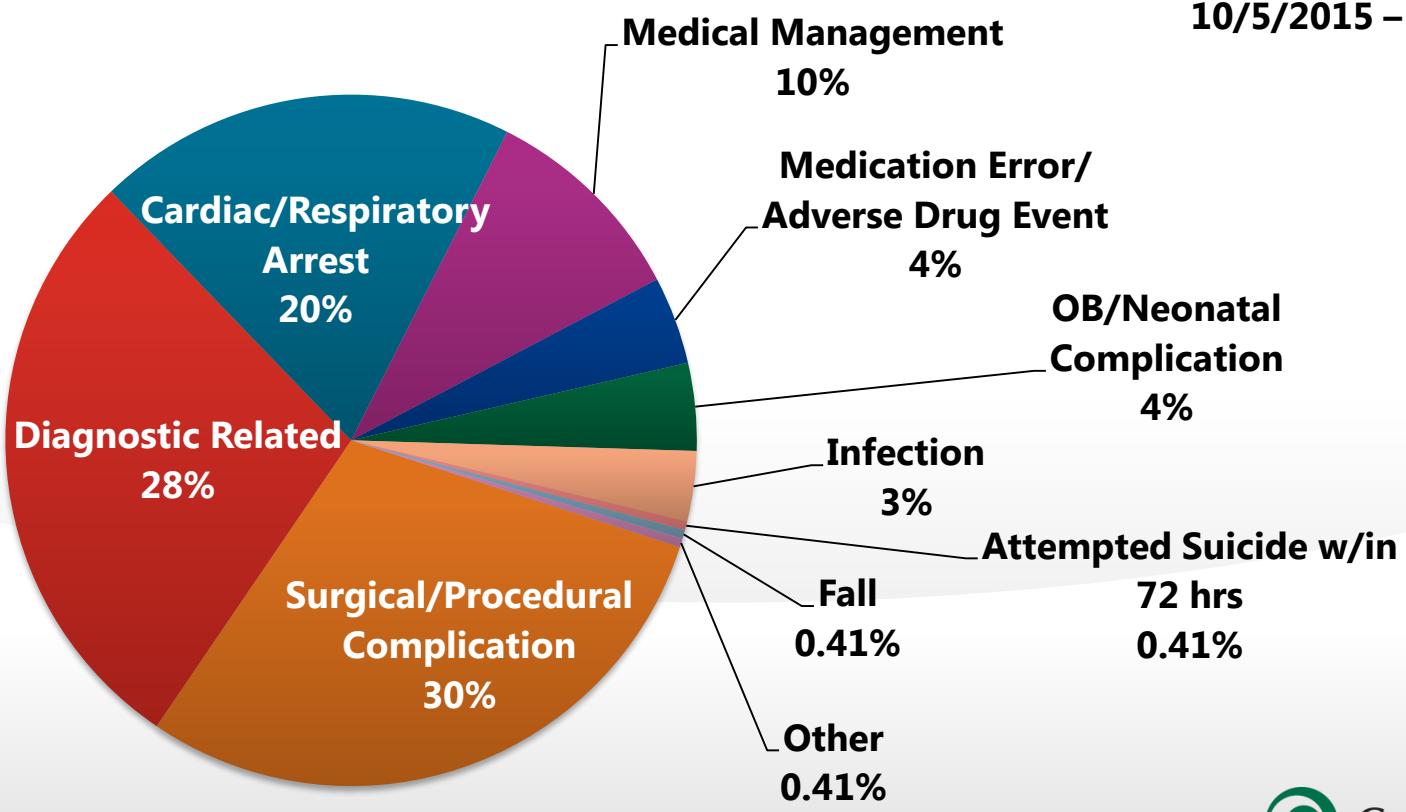
CANDOR Alerts Event Characteristics

10/5/2015 – 06/26/2019



CANDOR Alerts
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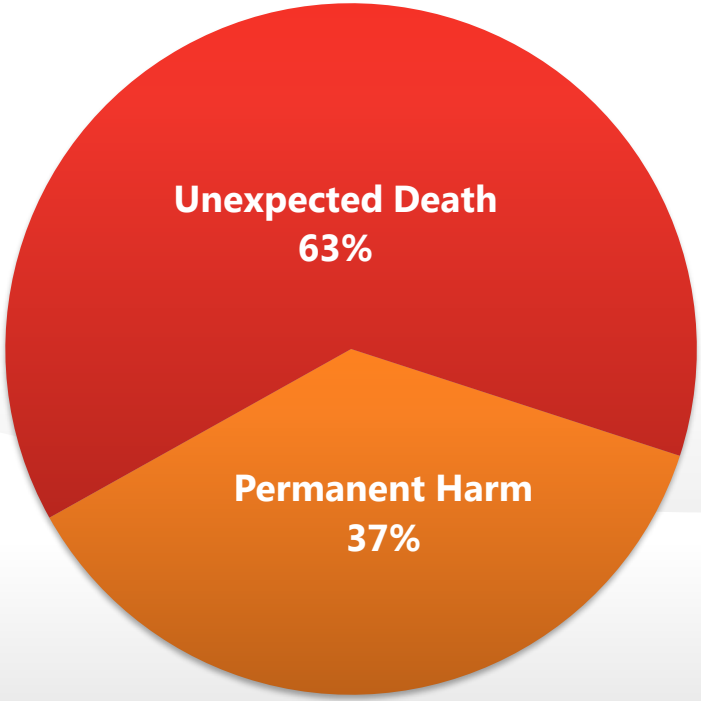
CANDOR Alerts Event Severity

10/5/2015 – 06/26/2019



CANDOR Alerts
n=244

Potential Interpretations

- Higher acuity populations, often multidisciplinary
- Most common event types:
  - Surgical/Procedural Complications
  - Diagnostic Related
  - Cardiac/Respiratory Arrest
- Majority of cases - unexpected death

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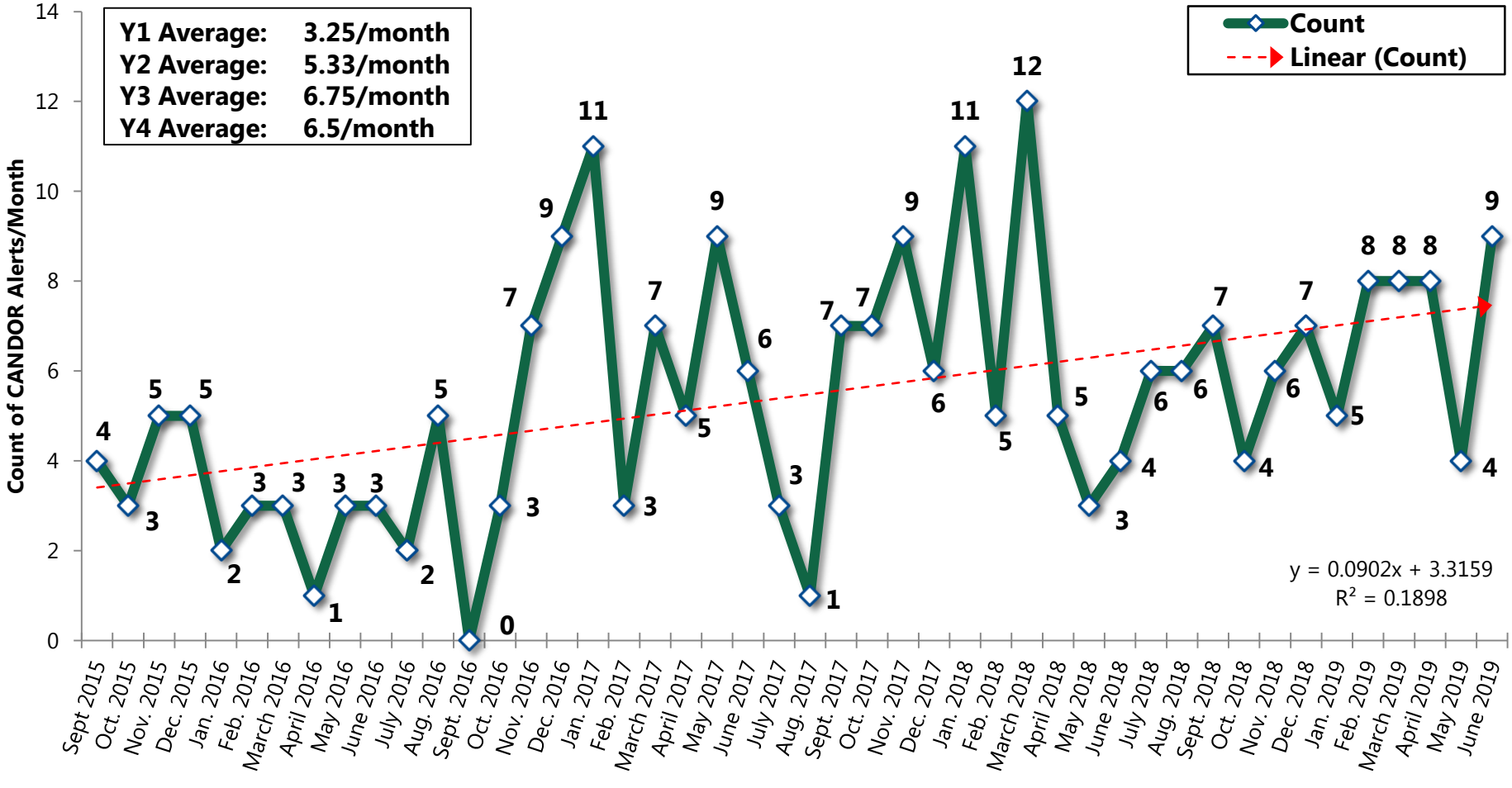
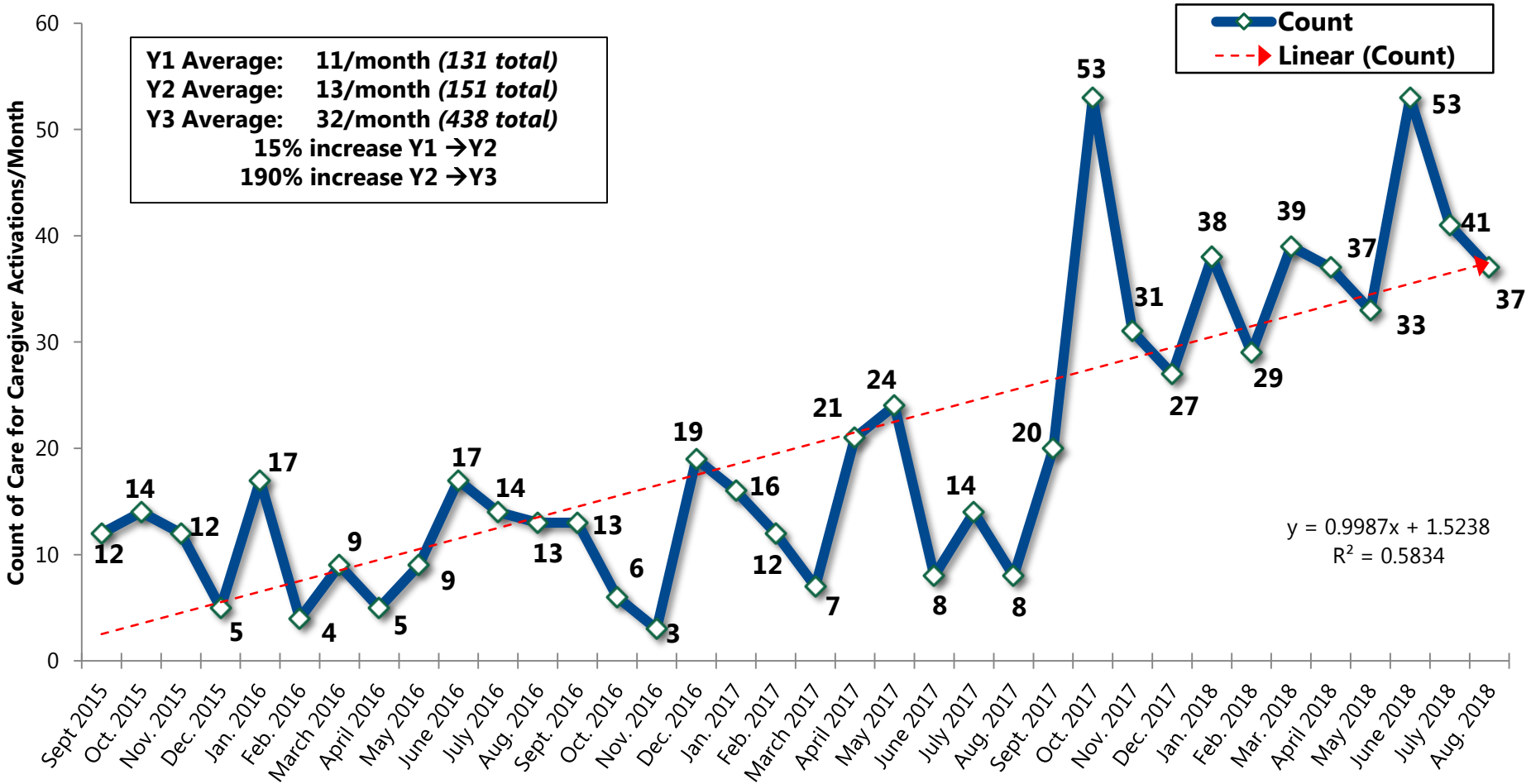
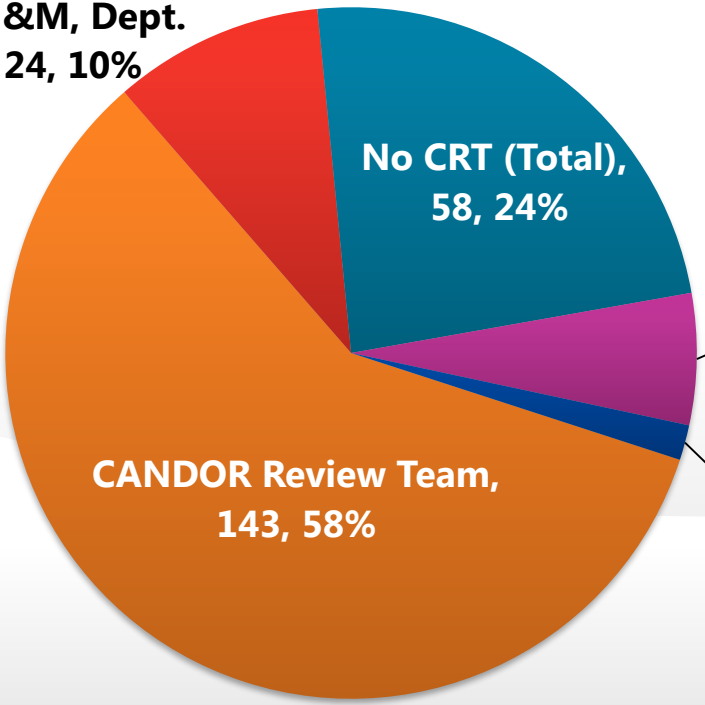
CANDOR Alert Volumes by Month



Care for the Caregiver Volumes by Month



CANDOR Process - Review Forum



CANDOR Alerts
n=244

10/5/2015 – 06/26/2019

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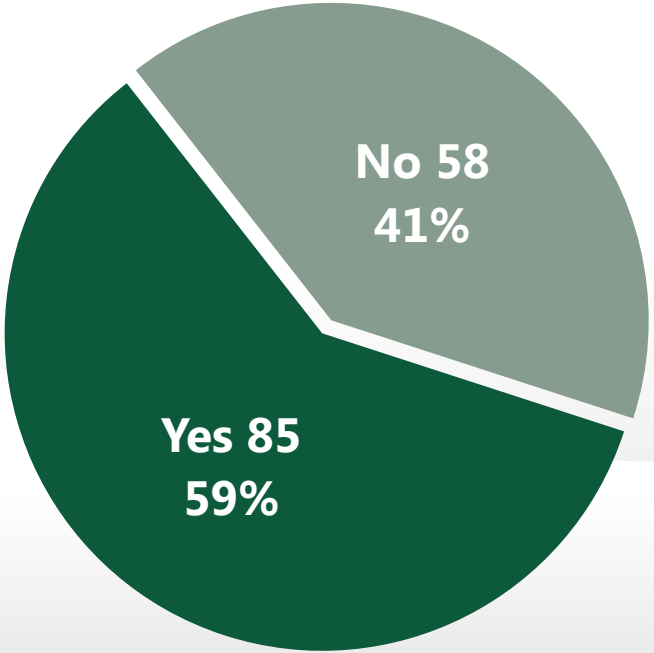
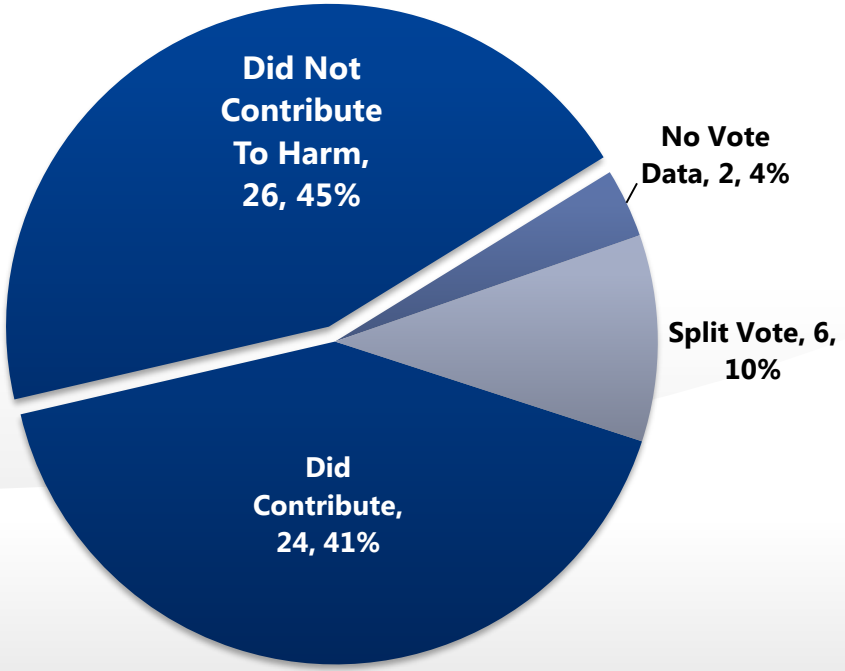
CANDOR Process – Standard of Care

"Were the generally accepted practice standards met?"



CANDOR Review Panels *n=143*
10/5/2015 – 06/26/2019

"Did medical care contribute to the harm?"



Q1 "Std not met"
n=58

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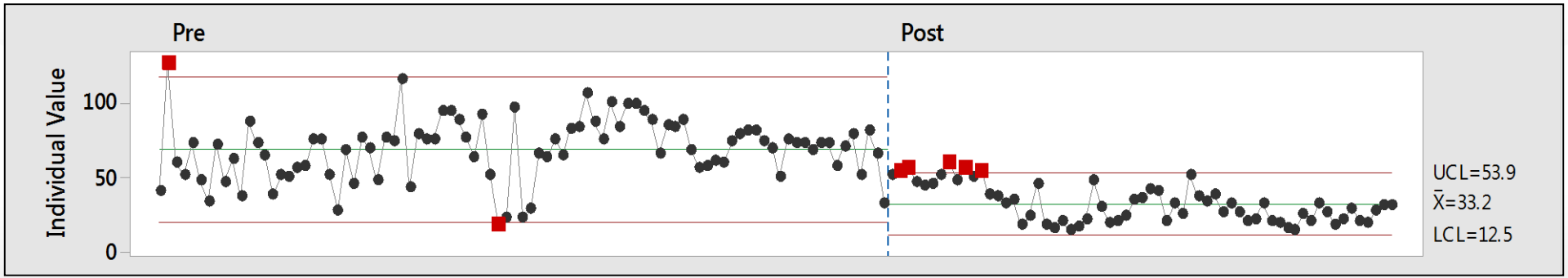
Time from Alert to Review Team (Business Days)

Goal – Reduce time to Review Panel by 50% starting Jan 2018

- Pre-intervention mean =~70 business days
- Post-intervention mean =~33 business days
- Reduction in standard deviation by 57.5%



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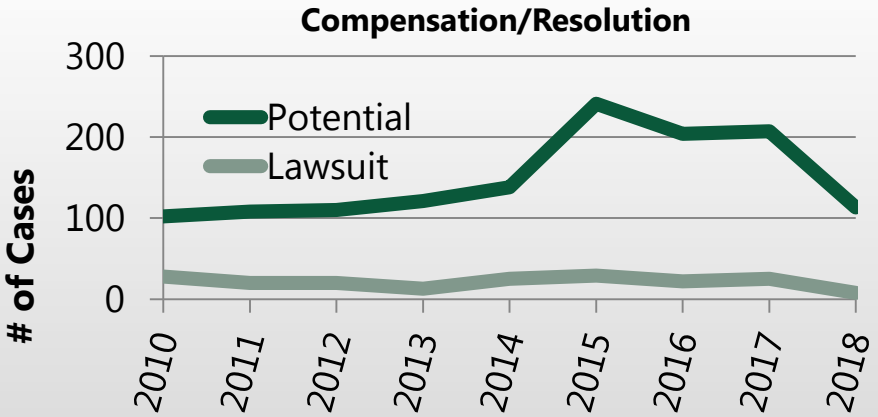
3 Year Totals for 188 CANDOR Cases:

- Approximately $2,038,575 in bills waived
- 12 lawsuits (1 settled); 10 claims filed (6 settled without litigation).
- Settlement total for 7 cases = $1,710,000
- To date, only 6% of cases resulted in lawsuit or claim

No increase in lawsuits received annually- however, statute of limitations should be considered



System Improvements

To date, over 140 system improvement opportunities have been identified.

Awareness increased through sharing lessons learned, process/outcome metrics.

Examples

- Failure Modes and Effects Analysis for telemonitoring system
- Revision of Dobhoff insertion process
- Improvement in Incidental Findings
- Expand POETS for patients undergoing AV fistula procedure

Critical Components

Event Management

- Review and Analysis
- Process Improvement & seeking new knowledge and learning

Communication

- Lead/guide the initial disclosure, subsequent discussions, and final disclosure

Care for the Caregiver

- Support for providers involved aimed at promoting psychological safety

Resolution

- Determination of causation and standard of care
- Settlement = Risk + Legal + Carrier

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Communication to Patients and Families Following Safety Events

Stephen A. Pearlman MD, MSHQS

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Medical Director, CANDOR Program

Clinical Professor of Pediatrics, Sidney Kimmel College of Medicine, TJU

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Goals

- To define the needs of patients and their families who have been involved in a safety event
- To outline the steps for effective disclosure
- To identify specific communication skills that will assist providers in leading these conversations

Disclosure – Practical Approach

- **First Steps**
  - Patient's medical needs met, notify attending, risk manager and administrator, plan a meeting
- **Prepare**
  - Discuss case, determine if disclosure is necessary, focus on patient and family, decide who will lead discussion, choose location and time, choose who will follow up
- **Discussion**
  - Be caring and humane, ask "what would I want to be told?", show compassion and empathy, apologize when appropriate, explain the plan going forward, explain investigation, address compensation, offer support, don't expect forgiveness or thanks

Initial Communication

Comprises:

- Assessing the patient/family understanding of what occurred
- Offer apology and provide immediate support
- Share and explain known facts
- Inform patient/family that a thorough review of the case will be completed and the findings shared
- Provide the name of the Patient Relations liaison who they can contact with questions

Rationale for Communicating Following Harmful Events

- Extension of informed consent
- Error disclosure as truth telling
- Regulatory requirements
- Joint Commission, hospital policy, State laws
- Need to meet patient expectations
- Possible reduction in legal liability

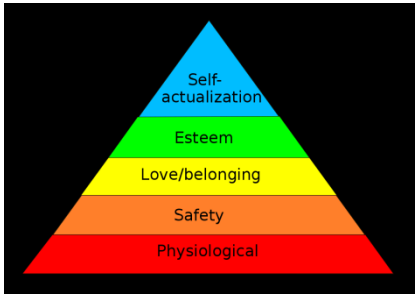
Patient/Family Perspective

- What they want to know initially
  - What happened
  - Implications for their health
  - We are taking responsibility
  - Hearing that we are sorry this occurred
- What they want to know later (not part of initial discussion)
  - Why this happened
  - What will be done to prevent further occurrences

Barriers

- Fear of litigation
- Low confidence in communication skills
- Shame/Embarrassment/Guilt

Needs



- **Patient**
  - **Honest, clear information (avoid medical jargon!)**
  - **Emotional support**
  - **Follow-Up**
- **Healthcare Worker**
  - **Good communication skills**
  - **Emotional support**

Skillset

- Genuine empathy, caring and concern
- Patients can tell when you are faking it
- Active listening is essential

Preparation

- Ensure that the patient's medical needs are being met when appropriate
- Anticipate their questions
  - Who is to blame? Who is going to pay for this? Who is getting fired? Do I need a lawyer? Generally these questions are really asking if we are taking this event seriously
  - Can I see the event analysis? The answer is that these are private hospital documents
  - Was a student doctor or nurse involved? Usually best not to answer
- If more than one participant establish roles and ensure agreement with message
- Ensure that caregivers are emotionally capable, sometimes may be better to have someone other than the provider involved meet with the family
- However, having those with a prior relationship is helpful

Essential components of Initial Disclosure

- Timeliness is critical
- Be factual
- No speculation – not the “Why”
- Avoid blaming anyone or a department/essential service

Agenda

- Review the facts
- Apologize – “I am sorry for what happened to you.” Is always appropriate
- Steps to care for the patient when applicable
- Who will speak to the family next and approximately when
- Offer support services e.g. Patient Relations
- Close with a sincere expression of support, empathy and concern

Empathy

- Listen to their emotion first and validate it
- Reflective listening is important
- They won't often hear us until they've been heard
- Be curious, ask open ended questions

Additional Tips

- Be Yourself – don't be too careful in choosing your words
- Silence is OK
- Anticipate potential reactions: anger, sarcasm
- Do not expect to be forgiven
- Expect that your answers to their questions may not satisfy them
- If you don't know an answer to a question, do not speculate
- Do not answer a question related to what someone else was thinking
- If they raise issues of financial resolution, acknowledge that it is a legitimate question that will be dealt with after the review is complete

What Not To Say

“We reviewed the care and found that we did everything right”

“The written results of our review are protected”

“It was the nurse’s fault for giving the wrong medication”

“The patient should have returned sooner for follow up care”

During the Disclosure

1. **Set the stage**
   - Silence pagers and phones
   - Find a suitable private room
   - Sit down
   - Introduce yourself and others present; describe the purpose of the conversation

2. **Listen and empathize**
   - Say you are sorry for the experience or for the outcome
   - Assess the patient's/family's understanding or "what happened"
   - Identify the key concerns
   - Actively listen/silence is okay
   - Acknowledge and validate the patient's/family's feelings

3. **Explain the facts**
   - Identify the adverse event early in the disclosure
   - Explain in a way that is easy to understand
   - Explain only what is known, do not speculate
   - Ask the patient/family to repeat back what they now understand of the event
   - Explain that a review will be done and we will share our findings when completed
   - Tell how the event may impact the patient's long-term health an what is being done right now

4. **Take responsibility**
   - Avoid blaming others or "the system"
   - State what will be done to prevent recurrences (for final disclosure conversation

5. **Close the discussion**
   - Discuss next steps and plan for a follow-up conversation
   - Ask if anyone has any final questions
   - Provide the name and contact information for the patient/family liaison and/or patient relations representative

6. **Document the conversation in the medical record. Include:**
   - Date
   - Time
   - Who was present for the conversation
   - Summary of the facts shared
   - Questions asked and answered, the patient's understanding
   - Next steps/follow-up plan

CHRISTIANA CARE

CANDOR COMMUNICATION COACH TIP CARD

Preparing for disclosure
- Identify and define goals
- Decide optimal timing for disclosure
- Define who should be present
- Anticipate patient and family questions
- Think about what you want to say
- Identify facts to be discussed
- Discuss follow up meetings

REHEARSE DISCUSSION WITH ATTENDING OR DESIGNEE

See reverse side of card

Contact
Kathleen McNicholas, MD (302) 379 - 7223
or
Stephen Pearlman, MD (302) 530 – 5552
for additional CANDOR assistance

Care for the Caregiver is available at
(302) 884 - 9321

Potential Linkages/Benefits

- Advances Safety Culture
- Supports Annual Operating and Long Term Organizational Goals to Reduce Patient Harm
- Grounded in *Just Culture* principles
- Promotes a *Learning* and *Reporting* culture
- Alignment with Mastering CLER & Resident Training
- Enhances commitment to Patient/Family Centered Care
- Mitigates liability and risk with reduction in claims and lawsuits
- May reduce medical malpractice premiums

Conclusions

- Open communication to patients/families involved in a serious safety event is the preferred approach and is consistent with our values and behaviors
- Providers need good communication skills and a good understanding on what these discussions entail
- The education provided in this presentation should help providers to feel more confident in carrying out communication with patients and their families after a serious safety event

We Serve Together

guided by our values
Excellence & Love

CHRISTIANA CARE HEALTH SYSTEM

EXCELLENCE

We commit to being exceptional today and even better tomorrow.

We seek new knowledge, ask for feedback, and are open to change.

We use resources wisely and effectively.

We are curious and continuously look for ways to innovate.

We are true to our word and follow through on our commitments.

LOVE

We anticipate the needs of others and help with compassion and generosity.

We embrace diversity and show respect to everyone.

We listen actively, seek to understand, and assume good intentions.

We tell the truth with courage and empathy.

We accept responsibility for our attitudes and actions.