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Implementing Communication-and-Resolution Programs in Hospitals

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Disclosures

I have no conflicts of interest to disclose

ELLE

ELLE > HAIR & BEAUTY > HEALTH & FITNESS

CAN A SINCERE "I'M SORRY" MAKE UP FOR MEDICAL MALPRACTICE?

During her operation, Celia Barbour's surgeon made an almost fatal error, one with long-term consequences on her health. He apologized for it profusely—should that be enough?

BY Celia Barbour | September 27, 2013

In light of all this, is Dr. P's apology still enough? Sometimes yes. Often no.

blood from draining effectively. In addition, my upper arm is numb because nerves were cut during surgery. The scars in my chest wall hurt when I take a deep breath. A surgery to remove this clot isn't an option, I've been told, so I inject myself with blood thinners each night, which leaves my stomach mottled with bruises. I face the possibility of lifelong damage from the blood thinners, and who knows what from the blood transfusions. And I have less money in the bank to cover it all.

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Today's Discussion

1. What is the Communication-and-Resolution (CRP) Approach?

2. Does it work?

3. What does it take to do it well?

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The CRP Approach

- Timely reporting and disclosure
- Rapid investigation
- Explanation and an appropriate apology always offered
- Compensation proactively offered if care was substandard
- Vigorous defense where provider's care was reasonable
- No preset limits on compensation
- Final release of claims required
- Attorney involvement welcomed

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The Model Catches On

First Wave:

- Lexington VA
- University of Michigan
- University of Illinois at Chicago
- Stanford University Medical Indemnity and Trust

Second Wave:

- 7 HealthPact partners (WA)
- 5 NYC hospitals
- 6 Massachusetts hospitals
- 10 Illinois hospitals
- University of Texas system
- Ascension Health system

Third Wave: HRET CANDOR project – 3 hospital systems

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The Appeal of the CRP Approach

- It doesn't require legislative action.
- It offers something for both provider organizations and patients.
- When done right, it can produce impressive results.

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Measurement Problems

- The plural of “anecdote” is not “data”
- Time-horizon problem
- Potential confounding, especially regarding safety improvement
- Variations in design and implementation across sites

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University of Michigan Health System

(Pre/post analysis, 1995-2000 vs. 2001-2007)

- Average monthly **rate of new claims**: 7.03 → 4.52 per 100,000 patient encounters ($p<0.05$)
- Median **time from claim reporting to resolution**: 1.36 → 0.95 years ($p<0.01$)
- **Patient compensation costs** decreased significantly
  - Mean per lawsuit: $405,921 → $228,208 ($p<0.01$)
- **Legal expenses** decreased significantly overall ($p<0.01$)

Source: Kachalia et al., Ann Intern Med 2010

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Seven Pillars Program

- University of Illinois Chicago reports:
  - Increase in patient safety event reporting from 1,500 to 7,500 per year
  - 50% reduction in new claims
  - Reduction in median time to resolution from 55 to 12 months

Source: UIC communication to AHRQ, 2012.

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PEARL Program

- Stanford University Medical Indemnity and Trust reports:
  - 36% drop in claim frequency in first 3 ½ years of program compared with 2 previous years
  - $3.2 million (32%) average annual reduction in premiums paid for the retained layer of losses (the largest component of total premiums)

Source: Independent actuary's analysis of 2007-2007 data on 50 PEARL cases, reported in Institute for Healthcare Improvement, *Respectful Management of Serious Clinical Adverse Events* (2011).

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Implementation Experiences Studied

- 6 pioneers
- 5 New York City hospitals
- 6 hospitals and multispecialty clinics in Washington State
- 2 Massachusetts hospital systems *(ongoing)*
- 3 hospital systems in western, midwestern, and eastern U.S. *(just launching)*

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Study Data

- Key informant interviews
  - n=45 at 6 early adopters
  - n=35 at 5 NYC hospitals (baseline, midpoint, and end)
  - n=46 at 6 facilities and a physician insurer in WA state
- Prospectively collected case data
  - n=125 at 5 NYC hospitals
  - n>800 at 6 MA hospitals (ongoing)
  - Risk managers entered data, with training and monitoring
  - Domains: incident characteristics; key elements of CRP process; outcomes

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Limitations

- No direct observation of CRP operation
- Self-serving bias, conscious or unconscious
- Recall bias
- Patient's perspective not directly represented

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Pioneers: Factors Facilitating Successful Launch

- Conviction that it was “the right thing to do”
- Adverse liability environment
- Strong champion(s)
- Trusting relationship between insurer and insureds
- Ability to point to early experience of others
- Investment in educating physicians about the value of the approach

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Pioneers: Keys to Successful Operation

- Talented administrators
- Support from clinical leadership
- Culture of disclosure
- Early reporting of incidents
- Flexibility of approach
- “Seamless” experience for physicians and patients

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Pioneers: Challenges Encountered

- Completeness and timeliness of incident reporting
- Physician education and enrollment
- Coordination with outside insurers
- Combating the perception of taking advantage of patients
- Whether to hold the line in cases where settlement seems expedient, but not just

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Pioneers: Reactions from Physicians

- Not a tough sell once you get them in the room
- Appreciate disclosure coaching
- Fearful of NPDB reporting
- Most physicians had very positive experiences overall
- Some would prefer to take their chances

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New York City: Areas of Success

- More robust disclosure practices
  - Project elevated the profile of disclosure
  - Disclosure training well received
  - CRP provided mechanism to confirm disclosure
- Stronger relationships between clinicians and Risk
- Improved tracking of reported events
  - More events being tracked
  - Closer attention to next steps, improved communication across offices
  - Greater effort to identify candidates for early settlement

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New York City: Implementation Gaps and Challenges

- Executing on proactive settlement
  - Few offers made where standard of care violated
  - Strong interest in settling “slam dunks”
  - Little appetite for compensating where family was not asking for it; mouse/cookie problem
- Varied experiences trying to win over surgeons
- Limited resources and heavy workload
- Variable levels of leadership support

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Washington State

- Inter-organizational, collaborative model
- Strong commitment at the outset, but hesitation at the gate
- Small victories in resolving particular cases and streamlining some working relationships
- Fairly good internal implementation at 1 facility
- But did not successfully implement a collaborative CRP

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Washington State: Implementation Gaps and Challenges

- Very low case accrual
- Conflicts among participants
- Barriers encountered:
  - Distrust
  - Consent-to-settle provisions
  - Insurer's distance from the point of care
  - Delays in incident reporting and communication
  - Workload and distractions
  - Lack of a clear implementation plan

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Massachusetts

- Programs initiated by highly engaged clinical leaders who hired full-time project managers
- Smooth sailing on implementation; rapidly accruing cases
- But resolution is more complex than predicted
- ¾ haven't involved standard of care violations
- Low physician familiarity with the program

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Key Lessons Learned

1. It’s not business as usual.
2. The program’s major function is explanation and apology.
3. It’s got to be homegrown.
4. Insurers have to be fully on board.
5. New resources may be needed.
6. Success requires bringing adversaries together.
7. The process has to be trustworthy.

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Advice from the Field

- "It has to be physician to physician" to drive culture change.
- Allocate another 0.5-1.0 FTE in Risk/Claims.
- Develop detailed protocols for notification of adverse events, patient communication, and resolution—with timelines, roles and responsibilities.
- Don't launch until the supporting pillars are in place (physician education, care-for-the-caregiver services, communication protocols, system for tracking the events through the CRP).
- Create a modest pool of money ($10,000 per incident) that can be used at risk managers' discretion to resolve small matters informally.
- Implement a CRP as part of a group of organizations that meet regularly to share experiences.
- When collaborating across organizations, discuss relationship problems openly, forgive missteps, and don't "haggle over pennies".
- Give it 5 years before you judge the CRP a success or failure.

Source: WA State key informant interviews

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Implementation Resources

- Massachusetts Alliance for Communication and Resolution following Medical Injury: www.macrmi.info
- The Risk Authority (Stanford): http://theriskauthority.com/advancement/webcasts/communication-and-resolution/
- AHRQ implementation toolkit (forthcoming from Health Research & Educational Trust in late 2015):
  - Disclosure training
  - CRP administrator training
  - Gap analysis tools
  - Workflow tools
  - Evaluation tools

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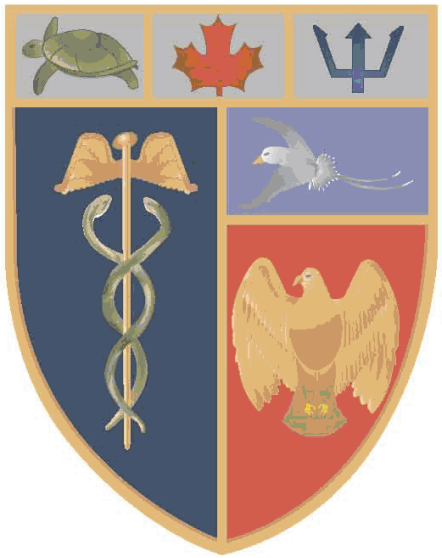
Thank You



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