Engaging Harmed Patients for Healing and Safety

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After Medical Errors,
Disclosure, Transparency, and Collaboration Can Meet the Needs of Everyone

Jeff Driver, Esq.
Chief Executive Officer of The Risk Authority Stanford

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PEARL: Process for Early Assessment, Resolution, and Learning

A collaborative approach to unanticipated significant medical outcomes.

A Hybrid Values/Claims Centric Model
CRP Principles Integrated into PEARL

- Transparency
- Compassion
- Justice
- Accountability

Four Early Rs

Recognition → Response → Review → Resolution

Helpful Resources

Communication and Optimal Resolution (CANDOR) Toolkit

The CANDOR process makes care safer by supporting health care organizations in fostering a culture of accountability, improvement, and transparency.

Collaborative for Accountability and Improvement

The Collaborative for Accountability and Improvement and its partners help organizations integrate CANDOR into how they respond to adverse events.
**PEARL Objectives:**

**Patients:**
- Explanation
- Full Apology
  Acknowledgement/Responsibility/Amends/Lessons Learned
- Improvements

**Hospitals:**
- Understanding
- Accountability
- Patient Safety

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**PEARL Team**

- Patient/Loved Ones
  - Provider
  - Clinical Risk Manager
- Claims Specialist
- Patient Liaison
- Leadership

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PEARL Patient Liaison

*Leilani Schweitzer*
Parent, Risk Manager, Patient Liaison

- Full-time Employee
- Guide to Patients/Loved Ones
- Single point of contact
- Sets Expectations
- Patient Advocate on the Claims Team
- Ensures timely assessment
- Administers reimbursement program
- Attends disclosure meetings

The Patient/Family Experience

- Injured/Grieving
- Confused/Scared
- Loss of Trust
- Motivated
  
  want answers/improvements
PEARL Care

• Limited reimbursement model

• Reimburses patient out-of-pocket costs

• Increase patient satisfaction & preserve the patient/physician relationship

Peer Support Program

• Studies have shown clinicians experience significant distress following critical clinical events.

• This distress affects them both emotionally, personally, and professionally and many report not feeling supported by their organizations. (Waterman 2007).

• Peer support is one way to mitigate burnout risk.

• A PEARL investigation is performed immediately after learning of an event, when the physician is still trying to process and recover from the impact.

• Peer Support program provides clinician support during PEARL, confidentially, by medical staff, on a voluntary basis.
TRA-Stanford Results

Pre vs. Post PEARL Results

<table>
<thead>
<tr>
<th>Metric</th>
<th>Desired Result</th>
<th>Observed Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawsuit Frequency</td>
<td>Lower</td>
<td>Lower</td>
</tr>
<tr>
<td>Average Claim Severity</td>
<td>Lower</td>
<td>Lower</td>
</tr>
<tr>
<td>(ALAE) Severity</td>
<td></td>
<td>(inconclusive in 2013)</td>
</tr>
<tr>
<td>Average Defense Costs</td>
<td>Lower</td>
<td>Lower</td>
</tr>
<tr>
<td>Closing Pattern</td>
<td>Faster</td>
<td>Unchanged</td>
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</tbody>
</table>

Pre PEARL period: FY 2003 to 2008
Post PEARL period: FY 2009 to 2014
Engaging patients in post-event learning

Jason M. Etchegaray, PhD

December 7, 2016
Root cause analyses typically include

• obtaining many important perspectives
  – Interdisciplinary team
  – Senior leadership

• though patient/family member perspectives are *not routinely included*


We sought to answer two interrelated questions

• Is there value in including patients/family members in post event analysis?

• What can patients/family members tell us about reasons events occur?
Study 1: Ways to structure patient involvement in event analysis

- Do patients know how hospitals work?
- What is the role of QI privilege/legal protections?
- How to involve patients without upsetting them?
- How to involve patients in post-event learning?


Do patients know how hospitals work?

- Interview patients to discover what they know about an event
- Do not make assumptions about patient knowledge
What is the role of QI privilege/legal protections?

• Determine whether patient involvement in analysis voids QI privilege
• Leadership needs to encourage patient involvement in privileged/protected processes
• Educate healthcare providers about legal protections to maximize patient involvement

How to involve patients without upsetting them?

• Determine patient’s physical and emotional distress
• Tailor timing and content of communications and activities
How to involve patients in post-event learning?

• Advocate not affiliated with the hospital
• Understand patient’s expectations about being involved
• Offer patients options to provide input based on preferences

Study 2: Are patients aware of contributing factors for events?

• All participants identified at least one contributing factor
• average = 3.67 contributing factors/participant

Etchegaray JM, Ottosen MJ, Aigbe A, Sedlock E, Sage WM, Bell SK, Gallagher TH, Thomas EJ. Patients as partners in learning from unexpected events. Health Services Research, in press.
Contributing Factors by Event Type

<table>
<thead>
<tr>
<th>Contributing Factor</th>
<th>All patients (n = 72)</th>
<th>Infection (n = 20)</th>
<th>Medication Error (n = 9)</th>
<th>Diagnostic Error (n = 11)</th>
<th>Surgical Error (n = 9)</th>
<th>Procedure Error (n = 8)</th>
<th>Inappropriate Care (n = 8)</th>
<th>Equipment Error (n = 2)</th>
<th>Fall (n = 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>44 (64%)</td>
<td>11 (55%)</td>
<td>9 (69%)</td>
<td>4 (44%)</td>
<td>4 (50%)</td>
<td>7 (88%)</td>
<td>1 (50%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
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<tr>
<td>Documentation/Charting</td>
<td>31 (15%)</td>
<td>0 (0%)</td>
<td>4 (31%)</td>
<td>2 (22%)</td>
<td>0 (0%)</td>
<td>1 (13%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
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<tr>
<td>Environment</td>
<td>17 (24%)</td>
<td>1 (8%)</td>
<td>4 (36%)</td>
<td>2 (22%)</td>
<td>0 (0%)</td>
<td>1 (13%)</td>
<td>0 (0%)</td>
<td>1 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Equipment/Device</td>
<td>14 (20%)</td>
<td>8 (40%)</td>
<td>2 (22%)</td>
<td>1 (13%)</td>
<td>1 (13%)</td>
<td>2 (100%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
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<tr>
<td>Human Factors</td>
<td>33 (46%)</td>
<td>14 (70%)</td>
<td>3 (23%)</td>
<td>5 (45%)</td>
<td>3 (33%)</td>
<td>5 (63%)</td>
<td>1 (50%)</td>
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<td>Safety Policies/Procedures</td>
<td>53 (74%)</td>
<td>17 (85%)</td>
<td>12 (92%)</td>
<td>7 (64%)</td>
<td>5 (50%)</td>
<td>5 (63%)</td>
<td>5 (63%)</td>
<td>1 (50%)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Staff Qualifications/Knowledge</td>
<td>57 (79%)</td>
<td>18 (90%)</td>
<td>11 (85%)</td>
<td>8 (73%)</td>
<td>6 (67%)</td>
<td>7 (88%)</td>
<td>5 (63%)</td>
<td>2 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Supervision/Support</td>
<td>14 (20%)</td>
<td>3 (15%)</td>
<td>2 (18%)</td>
<td>2 (22%)</td>
<td>1 (13%)</td>
<td>4 (50%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
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</tbody>
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What do patients know about hospital policies?

- "At one point [the physician] was examining me, and I noticed that he had walked over to the sink and he just sort of wiggled his fingers in front of the water and made this sort of perfunctory hand washing, but he didn't really. And so, then he started pushing his finger down into my open wound, and I said to him, you know, "Shouldn't you have washed your hands before your treating this wound?" And he said, you know, "My hands aren't any dirtier than your infection."
IMproving Post-event Analysis and Communication Together (IMPACT) Tool

- Build rapport
- Telling their story
- Diving deeper
- Recommendations and learning
- Thanks


Questions/Answers/Discussion
Healing After Harm

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WTGW: Voices of Patients and Families
The emotional impact of harmful medical error

“You feel like . . . 'I should have been there.' That's a guilt that everyone shares.”

“I was frightened to complain any more. . . I was scared that I would get more mistreated.”

“The sense that somebody could empathize . . . was almost totally lacking.”

Self-blame

Fear

Isolation

Delbanco and Bell, NEJM 2007
The Path to Exploring Long-Term Impacts of Medical Error on Patients and Families

Conference of Stakeholders

Secondary Analysis of Data
Secondary Analysis: Impacts of Medical Error on Patients and Families

- 72 Interviews
- Patients and/or their Family Members Harmed by Medical Errors
- 5 to 20 years Post-Event

Findings:

4 major types of long-term impacts:

- Psychological
- Social/Behavioral
- Physical
- Financial
Psychological Impacts

• Psychological Scars
• Anger
• Loss of Trust in Healthcare
• Vivid Memories
• Grief and Self-Blame

…they would not talk to me…they didn’t care that they had hurt me.

Nobody did.

..all of us who have been a victim or a survivor of patient harm, all share the same psychological scars.
No one was even calling to see how I was doing. It’s like you gave me a major infection, almost killed me, … And you’re not even calling to say, “Ms. X, are you okay?”.

**Anger**

What turns you into the bitter, angry patient is the fact that you can’t get answers…or key pieces missing out of your medical record…or the hospital won’t talk to you. Or you start to uncover lies that have been told to you.

It’s left a lasting impact on me
…I used to have a lot of confidence in our health care and now I don’t have much at all. I’m even afraid if I ever have to go to a hospital...

**Loss of Trust in Healthcare**

…I used to think hospitals were a place that you went to get adequate care and you got better and you came home. I didn’t realize you could go in with one thing, and then wind up dead from another and it terrifies me.
Social and Behavioral Impacts

- Altered Life and View of Self
- Altered Healthcare Seeking Behaviors
- Activism

Physical and Financial Impacts
Mapping the Patient/Family Post-Event Experience

AHRQ Conference:
Setting a Research Agenda for Studying the Emotional Impact of Harmful Events and Medical Errors on Patients and Families
Stakeholder consensus: Research priorities

Themes

Reflective Trigger Tour
and Gallery Walk
Do Now: Small steps toward a culture of transparency and healing

- **ASK** patients and their family members
  - Involve patients/families in research design, solutions, post-event learning
- **Tell Stories** – human element
- **Visible expert panel** (IOM, CMS) – Raise awareness
- Normalize, inform, support patients about emotional trauma
- **Speak up** (patient) and LISTEN (clinician) initiatives
- **Deepen/expand** clinician training for difficult conversations
  - Include patients in clinician training
- **Measures**: Triggers, reporting, RCA, HCAHPS
  - Make use of existing mechanisms
- **Longitudinal patient/family communication strategies**
- **Best practices** (for healing); Accountability
- **Urgency** – We cant wait
  - *(Perfect is the enemy of good…)*

Candle problem

“Patients the most under-utilized resource in health care”

Karl Duncker, 1945;
https://www.ted.com/talks/dan_pink_on_motivation?language=en
Summary and integration

1. Framework
   - CRPs, CANDOR, Collaborative

2. Tools
   - Linking disclosure to QI, patient/family roles
   - Involving patients/families in event analysis, contributing factors
   - IMPACT tool
   - “Do Now” suggestions to improve p/f experience

3. Future directions
   - More research needed – especially re: LTI, epidemiology
   - Questions about accountability, implications for CRPS and orgs
   - New ways of partnering with patients and families

Let’s discuss...

- What are patient and family experiences with harmful events in your organization?
- What are health care organizations’ responsibilities regarding long-term harm?
- What would this mean for CRPs in your organization and nationally?
- What tools/approaches have you seen used to partner with patients and families in healing and safety?
With Gratitude...

- Patients and families...
- Tom Gallagher
- Tom Delbanco
- Melinda Van Niel
- Linda Kenney
- Ken Sands
- Saul Weingart
- Pat Folcarelli
- Liz Gaufberg
- Elizabeth Lowe
- Emily Sedlock
- Aite Aigbe
- Bill Sage