

Health Systems Turn to Communication and Resolution Programs to Identify Errors

Pioneering adherents of this approach note that a policy of extreme honesty gets high marks from both patients and providers while enabling hospitals to prevent repeat errors

In its most recent Sentinel Event Alert, The Joint Commission (TJC) noted that too often healthcare leaders fail to create an effective safety culture, a problem that invariably leads to many types of adverse events. The accrediting organization cites several ways that inadequate leadership plays a role in adverse outcomes, but “insufficient support of patient safety event reporting” and “lack of feedback or response to staff and others who report safety vulnerabilities” are high on TJC’s list. (<http://bit.ly/2pExxo2>)

However, a few pioneering organizations have made great strides in significantly boosting the volume of errors that staff report dutifully, markedly improving the way these matters are reviewed and resolved. Organizations that have performed well in this area place a priority on making sure that preventable errors never happen again — a key goal inherent in any true culture of safety, but one that easily can fall by the wayside when legal matters take precedence over patient safety.

The good news for hospitals that are just now realizing that the traditional “deny and defend” approach for dealing with errors is due for a major overhaul? The early pioneers in this area have developed comprehensive tools and guidance so that the road can be smoother for those who follow suit. In line with TJC’s Sentinel Event Alert, **Richard Boothman**, JD, chief

risk officer in the University of Michigan Health System (UMHS) in Ann Arbor, maintains that there is no changing behavior with respect to the way errors and adverse events are handled without strong signals from leadership on what the expectations are and why.

“People can talk about safety all they want ... but if the

bottom line of any administrator is what the balance sheet looks like, the culture of the organization will be far more affected by bottom-line finances and not so much patient safety,” he explains. “So, culture is something that emerges over time, and it emerges from both messaging and the way an organization is structured.”

Boothman is well-positioned to understand how such culture change occurs. He was the driving force behind a transformation at UMHS, where error reports exploded from roughly 2,500 in 2008 to 36,000 in 2016. How does one convince healthcare workers to report errors and adverse events willingly?

There are three main requirements, according to Boothman:

- Healthcare workers must be in a culture that makes it safe to report;
- They must be encouraged to report with consistent messaging;
- It must be reasonably clear that good things will happen if they report errors and adverse events.

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What is most important to clinicians is the rationale behind the reporting, and what it will mean for patients.

“Honesty and transparency with each injured patient becomes important to the organizational mission of continuing quality improvement, of sparing our staff unnecessary litigation, and ... preserving the patient/physician relationship, even when things go badly,” Boothman observes. “It was that message that made a big difference in our staff’s acceptance of this, and in truth, their embracing of it.”

The results have been revelatory. Since Boothman began implementing the new approach in 2002, UMHS has experienced a steep drop in new lawsuits, malpractice cases that land in court, and the amount of compensation doled out to patients. At the same time, clinicians have been able to learn from their mistakes, and the health system has

been able to go after the root causes of errors quickly so that they are not repeated.

Support the Patient, Family

Most errors or near misses are reported through an electronic patient incident reporting system at UMHS, and these are divided promptly between events that harm patients and those that do not.

“If there is any injury at all, those get weeded out very quickly ... and we have a 24/7 response team, folks in the trenches at all hours of every day, who make an assessment almost immediately as to whether or not someone needs to get to the bedside,” Boothman notes. “The first thing we want to do is always support the patient and family.”

Boothman notes it is important to convey to the patient that you are

sorry this happened to him or her, that you will get to the bottom of exactly what happened, and that once you have that information, you will bring it to the patient. Meanwhile, you must take care of the patient’s medical needs.

“Concomitantly, we also need to take care of our staff because when these things happen, often it creates emotional harm and sometimes even physical harm to staff,” Boothman adds. “Thirdly, but most importantly, we need to make sure that whatever happened doesn’t represent an imminent threat to other patients.”

For instance, if there is a problem with a pump of some sort in one patient, it potentially could harm other patients.

“Our staff members are trained in stabilizing the situation, supporting the patient and staff, and preserving evidence, but also making sure that the environment is safe in the short term while we figure things out,” Boothman says.

EXECUTIVE SUMMARY

With healthcare leaders on notice that it is up to them to establish a safety culture, hospital systems are turning to communication and resolution programs (CRP) to identify errors and adverse events, and make sure patients are informed fully and compensated appropriately. Organizations that have pioneered such programs note that a policy of transparency is good for both patients and providers, and does away with the traditional “deny and defend” approach in which mistakes are buried.

- Since the University of Michigan Health System implemented a pioneering CRP program, error reporting has exploded from 2,500 in 2008 to 36,000 in 2016. At the same time, there has been a steep decline in new lawsuits, malpractice cases that land in court, and the amount of compensation awarded to patients.
- The Massachusetts Alliance for Communication and Resolution following Medical Injury has implemented a similar approach in participating hospitals across the state as well as in a multispecialty physician group.
- Experts have observed a dramatic increase in healthcare organizations interested in developing CRPs in the past 12-18 months, but warn that the inconsistent implementation of such a program will send a corrosive message to healthcare workers.

Disclose and Engage

A risk management team will begin investigating an error or adverse event immediately to determine whether the care the injured patient received was reasonable under the circumstances or whether the patient should be offered compensation. At the same time, another team under the patient safety office will “fly into action” to make sure the adverse event never happens again, Boothman notes. This team will perform the root cause analysis, determine if there was a sentinel event, and then come up with an action plan, he explains.

If the risk management team determines that the patient deserves compensation, then an offer will be

made. Conversely, if it is determined that the caregivers acted reasonably, the patient is entitled to a full explanation, Boothman notes.

“That patient is still entitled to us staying in the saddle with them clinically and doing our best for them to make sure their care is handled, but I might not compensate,” he says. “We still view that entire explanation and engagement with the patient as a form of resolution.”

In the past, hospital lawyers have defended against everything, regardless of the circumstances, Boothman observes. That’s why he maintains that the impetus for this type of approach must come from clinical leaders.

“You don’t do us any favors defending care we are not proud of,” he says. “You must conform your insurance, your risk management, and your legal response in these situations to be consistent with [the hospital’s] own evaluation because in this whole business of disclosure, the first disclosure is the one we make to ourselves when we look in the mirror and say we should have done better in this circumstance.”

However, Boothman argues that hospitals must be equally aggressive at defending clinicians who have done nothing wrong.

“I had a client once who thought every single case had value as long as he could settle it [at less expense] than it would cost to defend the case,” he recalls. “I think that is just as toxic as turning people away who deserve compensation because then staff get the idea that this is just a legal game, and they don’t have to be accountable.”

Boothman has worked with the Agency for Healthcare Research and Quality to develop resources for other healthcare organizations that are interested in the approach used

at UMHS. The Communication and Optimal Resolution (CANDOR) toolkit has been tested at 14 hospitals in three health systems in recent years. (<http://bit.ly/2m9fch7>)

Get Stakeholders on Board

Other health systems also have made progress in revolutionizing the way they handle mistakes and resolve these issues with affected patients and families. The Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) has developed a model that has grown to include several hospitals throughout the state as well as a multispecialty group of physicians.

“Our interest was how do you take a model that has worked in a closed system with its own insurer, [such as UMHS], and disseminate it across the state,” observes **Alan Woodward, MD**, an emergency medicine physician and chair of the committee on professional liability at the Massachusetts Medical Society in Waltham, MA.

With the help of \$300,000 in grant funding, investigators developed a roadmap for how to implement a system that had never been implemented or disseminated as a statewide initiative.

“We identified the 12 significant impediments and strategies on how to overcome each of those,” Woodward notes. (<http://bit.ly/2qubcaH>)

For starters, Woodward says that the group had to get lawyers and hospital administrators on board, and it had to pass enabling legislation.

“We had to get a whole host of groups to buy into this concept, so you have to find champions within every entity and organization,” he advises.

The MACRMI board includes representatives from the Massachusetts Health and Hospital Association, the Massachusetts Medical Society, the most prominent legal associations in the state, patient safety and advocacy groups, and liability insurers.

“We also got the health insurers on board, and they were the ones who helped fund us with the implementation of this,” Woodward explains.

Go for Extreme Honesty

The MACRMI approach includes a CARE Timeline that plots what steps must be completed, beginning within 48 hours of when an error or adverse event occurs, and culminating three to six months after the event when a meeting between all stakeholders occurs for resolution, and potentially an offer of compensation to the patient. (<http://bit.ly/2qA8LTk>)

The pillars behind the approach echo what Boothman installed at UMHS, and similar results have followed.

“If you develop first the Just Culture and second of all, a commitment to this model, the incident reports of near misses and actual misses will go up,” Woodward observes. “That is what we find at the institutions that implement this, but it isn’t just a matter of getting physicians to report; it is getting them to buy into the concept.”

This is difficult because most providers have been told for decades that if something goes wrong, they shouldn’t talk to anybody, Woodward explains.

“You can’t even talk to your spouse because anyone you talk to

other than your lawyer will be deposed if you carry on a conversation, which is incredibly damaging to physicians and providers,” he says. “The institution doesn’t learn, and instead it buries its mistakes.”

Further, when cases end up in court, a process that generally takes years, patients never get an apology, Woodward observes.

“That is critically important to them in dealing with their anger, and it is also critically important for the providers in dealing with their grief,” he says. “This is the concept that extreme honesty is the best policy, and it doesn’t cost more. It improves patient relationships with the institution and it improves provider satisfaction dramatically. It is hard to get physicians to agree with anything, but satisfaction with this program is incredible. It is overwhelmingly positive.”

Consistent Transparency

Thomas Gallagher, MD, a professor and associate chair in the department of medicine at the University of Washington, and executive director of the Collaborative for Accountability and Improvement, an organization committed to advancing the spread of Communication and Resolution Programs (CRP), is heartened to observe a dramatic increase in healthcare organizations interested in developing CRPs in the past 12-18 months.

“We are seeing a lot of organizations that are aware of peers that are moving in this direction, and they’re increasingly realizing that this is the direction in which the field is headed, and they can either be behind the curve or try to be part of one of the earlier waves of these types of programs,” he explains. “I think the field

has really hit a tipping point.”

Further, the research and evidence base has been strengthening, so there is more information on the benefits that can be achieved as well as some of the challenges involved with trying to implement an effective CRP, Gallagher observes. For instance, he notes that some of the early programs have been too dependent on the leadership of charismatic individuals to drive their success.

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“That does pose a threat when those individuals leave before a program is really institutionalized,” he says. However, Gallagher notes that the biggest threat he sees in the field today has to do with inconsistent implementation. “That inconsistent use happens in one of two ways. One is that they use the whole CRP, so all of the essential elements, in some cases but not others, or they use some aspects of the CRP for a given case, but not all of the essential elements,” he says.

An example of this would be an organization that has early event reporting for a case, speaks to the

patient and family about what happened, analyzes the event, makes plans to prevent recurrences, and has care for the caregiver, but then decides not to make an offer of financial compensation to the patient when compensation is warranted, Gallagher explains.

“The big problem of inconsistent implementation is it sends a corrosive message to the healthcare workers at the organization,” Gallagher stresses. “If they see that the organization is open and transparent with patients, except when it is inconvenient or embarrassing, or when the patient wouldn’t know about what happened unless you tell them, then what the healthcare workers take away from that is that they can report adverse events except when they don’t feel like it or it is embarrassing or inconvenient.”

Gallagher adds that when institutions use the programs inconsistently, it degrades the culture.

“These are first and foremost patient safety programs, and they rely on driving that culture of complete openness, transparency, and learning,” he says. ■

SOURCES

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