EARLY RESOLUTION

SORRY WORKS!® / COMMUNICATION AND RESOLUTION PROGRAM ("CRP")

Presented by Intercare
In association with DHS and COLA Risk Management
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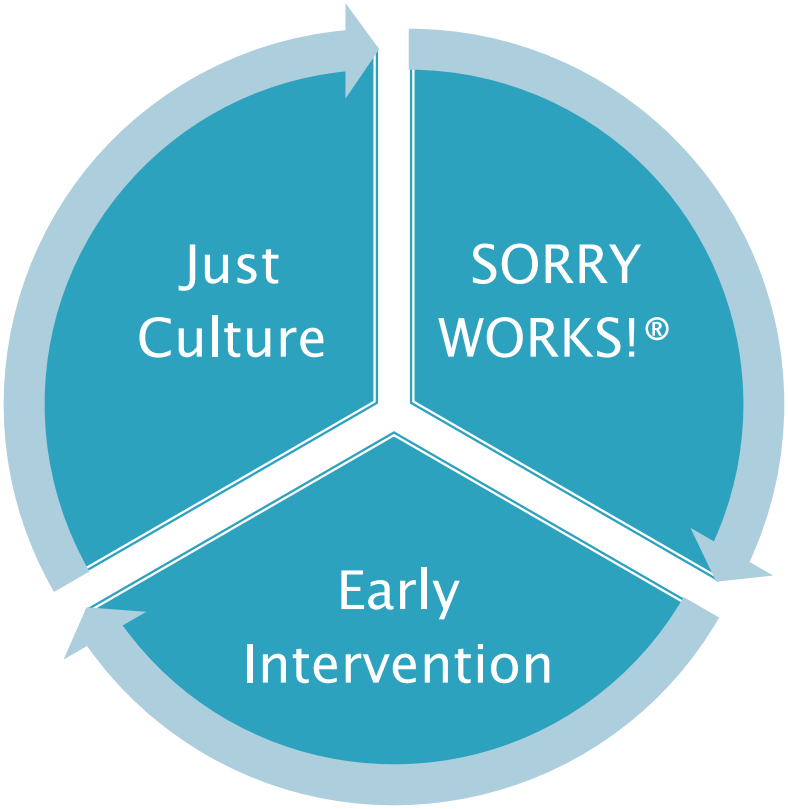
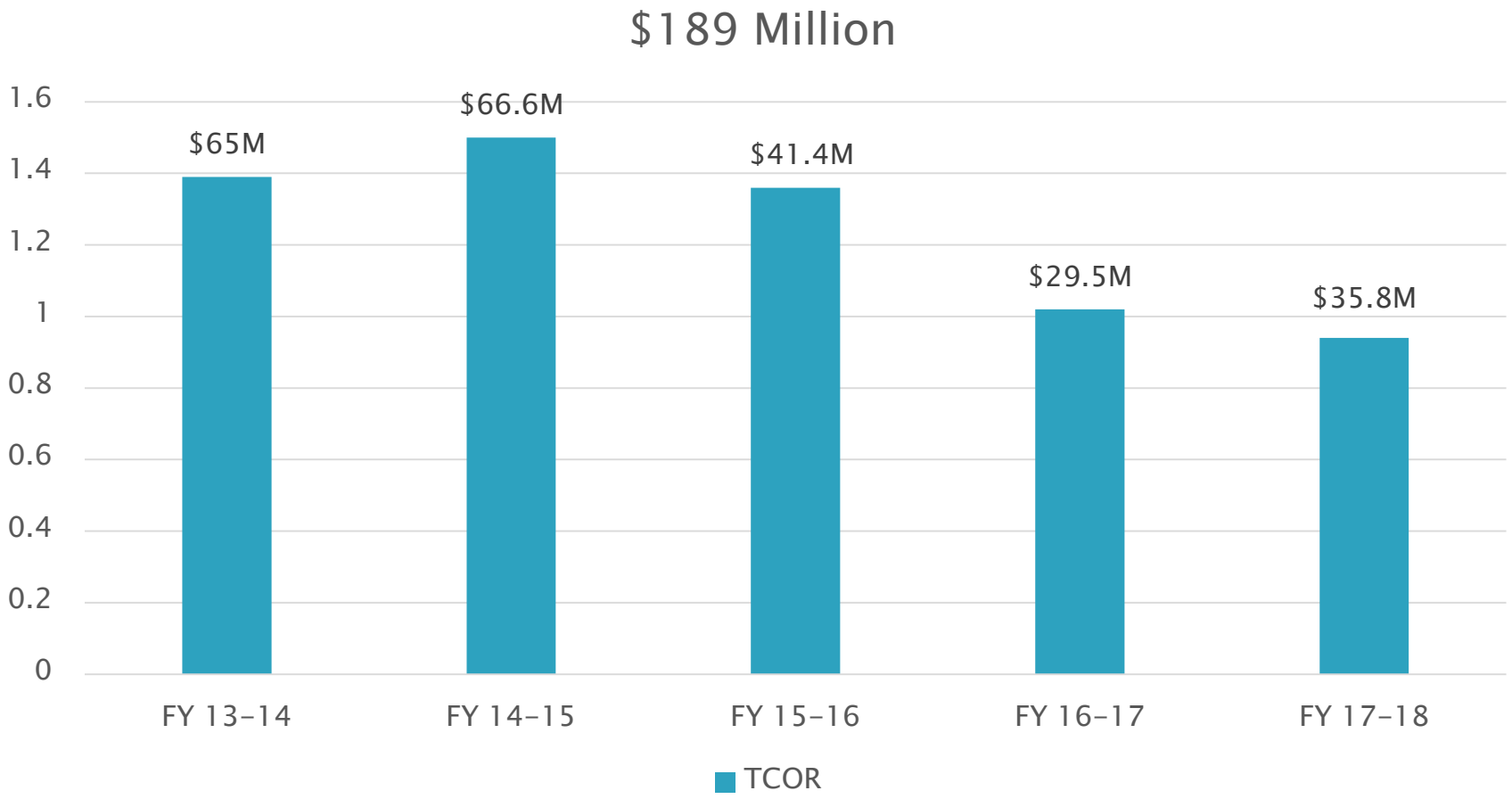
Tuesday, February 12, 2019
10:45 am

ER Paradigm



TCOR vs Actuals



History of SORRY WORKS!®

- Doug Wojcieszak lost his brother to medical errors in 1998.
- No empathy from the medical professionals involved.
- Sued hospital and physicians resulting in settlement.
- Created “Sorry Works!” to promote full disclosure and apologies for medical errors and mishaps.
- Sorry Works! Coalition established in 2005.

Today's Goals

- Understand the core components of a CRP and why each component is critical to a CRP's effectiveness.
- Consider the common barriers healthcare organizations experience when implementing a CRP and strategies for overcoming them.
- Identify skills for communicating with patients following adverse events and providing peer support.

- We know that patients can be unintentionally harmed in the context of care.
- The best risk management is not to hurt our patients in avoidable or preventable ways.
- The second-best is not to do it again!
- When an adverse event occurs, consideration should be given to the patient we have not hurt yet!

Impact of Unanticipated Clinical Outcomes

- Financial exposure / litigation.
- Patient needs: Care, financial, emotional.
- Staff needs: emotional/safety.
- Public relations concerns.
- Regulatory concerns.
- Future patients at risk?

- **Long-Term: Focus on Improvement**
- We will support our staff when the healthcare involved was reasonable.
- We will reduce patient injuries (and claims) by learning from our patients' experiences.

It serves patients' and families' needs.

It serves our caregivers' needs.

Most importantly, it serves our organization's core mission.

Reactions

"Why in heck would we do THIS?

We're already paying out a king's ransom!
You must be insane."

Why DO we do this?

- Because “it” is the single best way to build ownership and accountability for the quality and safety of the care we provide to the people who place their lives in our hands.
- Because it is the best way to serve the people who dedicate their lives to delivering that care.
- And consequently, it’s the best way to serve the organizations whose very reason for being is to deliver optimal health care.

“IT” is a thoughtful, principle-based, and integrated response to unanticipated clinical events that best serves our core health care mission in both, the short-term and long-term.

If you are focused on continual improvement and delivering an optimal patient experience within the clinical environment . . .

Why the heck would you NOT do “IT”?

Hard to Discuss

"There's no easy way I can tell you this, so I'm sending you to someone who can."

CRP Proven Success

- **U. Michigan**
  - Average monthly rate of new claims decreased
  - Median time from claim reporting to resolution decreased
  - Average patient compensation costs decreased
  - Legal expenses decreased

- **University of Illinois Chicago:**
  - Event reporting increased from 1,500 to 7,500 per year
  - New claims dropped 50%
  - Median time to resolution dropped from 55 to 12 months

- **Stanford University Medical Indemnity and Trust**
  - Frequency of lawsuits nearly 50% lower
  - Indemnity costs in paid cases 40% lower
  - Defense costs 20% lower for cases handled through the CRP

CRP Commitments

- **A CRP requires that healthcare organizations and their clinicians commit to the following:**
  - Being transparent with patients and families
  - Analyzing adverse events and closing gaps in care
  - Supporting the emotional needs of patients, families, and caregivers
  - Offering proactive financial and non-financial resolution for unreasonable care
- **Educating patients about their right to seek legal representation at any time.**
- **Working collaboratively to respond to adverse events involving multiple parties.**
- **Continuously assessing the effectiveness of the CRP program.**

Challenges

- Provider fear of lawsuits and disciplinary actions
- Overcoming organizational status quo
- Discordant relationships among hospitals, risk management companies, and the legal community

Consequences of Failed Response to Adverse Events

- Compounds suffering of patients and family
- Heightens distress of clinicians
- Increases likelihood of litigation
- Lost opportunity for learning within and across institutions
- Degrades institutional culture/climate
- Reduces public trust in healthcare

What's wrong with "disclosure"?

- **Implies we will be doing most of the talking.**
  - Reality: 75% is listening –empathic and mindful.

- **Implies we will have only one conversation.**
  - Reality: it is a process that helps us to have a richer understanding of what happened, of the consequences of what happened and informs next steps.

- **Implies it only is used when we have secrets to tell.**
  - Reality: it needs to become the norm, an expectation for full and open communication in all unanticipated clinical outcomes.
  - Reality: it powerfully informs us of gaps in informed consent.
  - Reality: it's greatest transformative power is to shape future quality improvements in patient/caregiver relationships.

Discipline in disclosure is crucial

- Must know when NOT to talk –it's not about us!
- Must be able to hear it all –anger, fears, guilt, threats, misconceptions, misunderstandings, misinformation.
- Must be able to discern unspoken needs, demands.
- Must be prepared for surprises.
- Control what comes out of our mouths.
- Know the difference between fact and supposition, assumption, speculation, guess.
- Know the difference between an excuse and explanation.
- Must know the boundaries.
- Must know when to quit.

Communication 101

- **Patients need –**
  - Truthful, accurate information
  - Emotional support, including apology
  - Follow-up, potentially compensation
- **Health care workers need**
  - Communication coaching
  - Emotional support
- **Process, not an event**
  - Initial conversation
  - Event analysis
  - Follow up conversation

What drives patients to sue their care givers?

Four common themes:

1) The need for an explanation.
2) A desire to ensure the safety of others.
3) Sense of accountability.
4) Compensation.

A Moral Dilemma

- Often a HCP is placed in a moral dilemma—wanting to soothe the feelings of the patient or family while simultaneously wishing to avoid having an apology used against him or her in court.
- A number of states have passed "**Apology Laws**" that prohibit the use of a physician's apology as an admission of fault in court. With these laws, an apology now has the ability to mitigate the results of an unanticipated or poor medical outcome

JUST CULTURE (County of LA)

- Making the process fair and kind.
  - Do what is right for the employee healthcare providers.
  - Do what is right for the patient/patient's family.

History of “Apology Laws”

Massachusetts was the first state to enact an apology law, in 1986.

34 other states along with the District of Columbia have enacted laws that prohibit a physician's apology as admissible evidence in a legal proceeding.

Most apology laws apply to statements and gestures of benevolence made to either a patient or that patient's family in the wake of an unanticipated outcome.

California "Apology Laws"

CA EVIDENCE CODE - DIVISION 9. EVIDENCE AFFECTED OR EXCLUDED BY EXTRINSIC POLICIES [1100 - 1160]

1160.

(a) The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section.

(b) For purposes of this section:

(1) "Accident" means an occurrence resulting in injury or death to one or more persons which is not the result of willful action by a party.

(2) "Benevolent gestures" means actions which convey a sense of compassion or commiseration emanating from humane impulses.

(3) "Family" means the spouse, parent, grandparent, stepmother, stepfather, child, grandchild, brother, sister, half brother, half sister, adopted children of parent, or spouse's parents of an injured party.

The 8 essential practices for communication and resolution programs ("CRP")

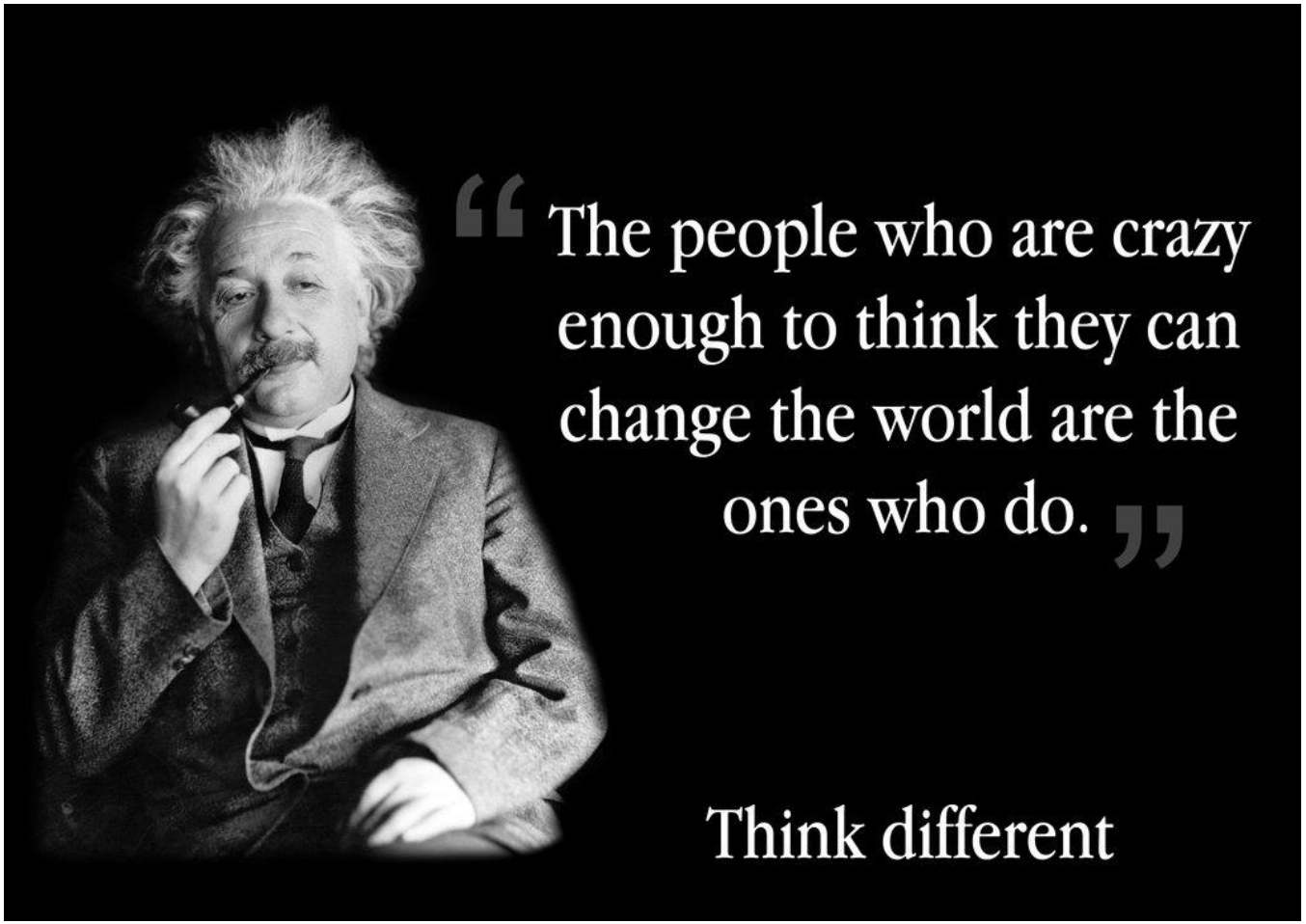
- Immediately report adverse events to the healthcare institution (within 30 minutes of the event's discovery).
- Communicate with patients about what happened, whether it was preventable, why it happened, and how recurrences will be prevented.
- Analyze adverse events using human factors principles and develop action plans to prevent recurrences.
- Support the emotional needs of the patient, family and care team.
- Proactively and promptly offer financial and non-financial resolution to patients and families when care is unreasonable.
- Educate patients and families about their right to seek legal representation at any time.
- Work collaboratively with involved healthcare organizations and professional liability insurers to resolve adverse events.
- Assess the effectiveness of the CRP program using tested and accepted measures.

Bedrock Principles

- Tell patients who are involved in an adverse outcome –what we know when we know it.
- Compensate quickly and fairly when inappropriate medical care causes injury.
- Support staff vigorously when the healthcare involved was reasonable.
- Reduce patient injuries (and claims) by learning from our patients' experiences.

In Preparation: Questions to Consider

- What are the goals of the interaction?
- When should you respond to the patient/family?
- Who should respond to the patient/family?
- What questions do you anticipate getting from the patient/family?
- What are you going to say to the patient/family?
- What information should be shared/discussed?
- Who continues to respond to the patient/family as more information is discovered?
- How do you respond to your caregivers?


“The people who are crazy enough to think they can change the world are the ones who do.”
Think different