The Seven Pillars: Crossing the Patient Safety – Medical Liability Chasm

Timothy B McDonald, MD JD
Professor, Anesthesiology and Pediatrics
University of Illinois College of Medicine
Chief Safety and Risk Officer for Health Affairs
University of Illinois Hospital and Health Sciences System

News Release

FOR IMMEDIATE RELEASE
Friday, June 11, 2010

Contact: HHS Press Office: (202) 690-6343
AHRQ Public Affairs: (301) 427-1855

HHS Announces Patient Safety and Medical Liability Demonstration Projects
Funds Allocated to Develop, Implement, and Evaluate Patient Safety Approaches and Medical Liability Reform Models

Largest federal investment connecting medical liability to quality

Demonstration Grants:
Timothy McDonald, M.D., J.D., University of Illinois at Chicago, IL, $2,988,083
Stanley Davis, M.D., Fairview Health Services, Minneapolis, MN, $2,962,650
Eric Thomas, M.D., M.P.H., University of Texas Health Science Center, Houston, TX, $1,796,575
Ann Hensrud, M.S., R.N., F.A.A.N., Ascension Health System, St. Louis, MO, $1,950,612
Thomas Gallagher, M.D., University of Washington, Seattle, WA, $2,772,209
Judy Mager, J.D., New York State Unified Court System, New York, NY, $2,925,787
Alice Benner, M.S., APRN, BC, Massachusetts State Department of Public Health, Boston, MA, $2,912,500

© 2008 The Board of Trustees of the University of Illinois
Overview of Patient Safety

- April, 1982 ABC 20/20 show: “The Deep Sleep – 6,000 will die or suffer brain damage…from carelessness”

- 1983 ASA Committee on Patient Safety and Risk Management created – closed claims analysis
- 1984 Anesthesia Patient Safety Foundation
- 1986 Monitoring standards established
Overview of Patient Safety

- Anesthesia Mortality Risk
  - 1982 - 1:2000
  - 2011 – 1:300,000
  - Substantial reduction in malpractice premiums

Some more background

Institute of Medicine: 1999 report that shook the medical world
Some more background

Institute of Medicine: 1999 report that shook the medical world

Making Matters Worse

© 2008 The Board of Trustees of the University of Illinois
Part of the issue

Health Affairs

February 2012, Volume 31, Issue 2

Survey Shows That At Least Some Physicians Are Not Always Open Or Honest With Patients

Lisa I. Iezzoni1,*, Sowmya R. Rao2, Catherine M. DesRoches3, Christine Vogel4 and Eric G. Campbell5

Impact on the medical malpractice community

Doctors Lie to Patients to Avoid Accountability Says Arkansas Personal Injury Lawyer

Little Rock, AR (Law Firm Newswire) April 11, 2012 – We trust our doctors to do what is right for us. Are they lying to us?
A case that makes the point

- The beginning circa 2000
  - The K.C. case, COO of sister hospital
  - Preoperative testing prior to plastic surgical procedure
  - Evening before surgery - lab tests done
  - WBC <1,000 (normal value 4-12,000)
  - Only Hgb & Hct checked on day of surgery
  - Repeated CBC (complete blood count) postop
  - WBC <600
  - Called as critical result to the unit – reported to “Mary, RN”
  - Never found out who “Mary, RN” was

One approach when things went wrong years ago

- Patient discharged from hospital on post-op day 3
- Died 6 weeks later from leukemia
- Physician colleagues/friends reported death to Risk Management
- Legal Counsel & Claims Office were approached with a plan for “making it right”
- All attempts to disclose, apologize, or provide remedy were rejected by University
Extreme Honesty

Barriers
- Fears
- Litigation
- Data Bank
- Shame, blame
- Reputation
- Lack of skills
- Lack of process

Benefits
- Learning
- Improving
- Less litigation
- Lower costs
- Integrity
- Morale
- Healing
Adding to the equation

- Journal of Trauma, September, 2010
  
  All Trauma Surgeons Are Not Created Equal: Asymmetric Distribution of Malpractice Claims Risk
  
  Kaushik Mukherjee, MD, MSCI, James W. Pichert, PhD, M. Bernadette Cornett, MA, Ge Yan, MS, Gerald W. Hickson, MD, and Jose J. Diaz, Jr., MD, FACS
  
  - 8% of physicians generated 34-40% of unsolicited patient complaints
  - Same 8% generate 50% of risk management expenses
  - Physicians in bottom q-tile of patient satisfaction have 110% malpractice risk

University of Illinois approves

Comprehensive “communication-resolution” program prevent and respond to harm

- Comprehensive
- Integrate safety, risk, quality and credentialing
- Linkage to claims and legal
- Longitudinal patient safety education plan
  - UGME
  - GME
  - CME
  - UIC Institute for Patient Safety Excellence
A Comprehensive Response to Patient Incidents: The Seven Pillars.
McDonald et al Quality and Safety in Health Care, Jan 2010

- Reporting
- Investigation
- Communication
- Apology with remediation – including waiver of hospital and professional fees
- Process and performance improvement
- Data tracking and analysis
- Education – of the entire process

Goals of the Seven Pillars

- Reduce harm thru transparency and learning
- Reduce lawsuits through early, effective communication with all parties
- Resolve inappropriate care cases early, efficiently
- Defend appropriate care vigorously
- Support patient and family engagement
- Support care professionals following harm events
The Original Seven Pillars: A Comprehensive Approach to the Prevention and Response to Patient Events

Data Base

No

Patient Harm?

Yes

Consider “Second Patient” Error Investigation
Hold bills

Inappropriate Care?

Yes

Full Disclosure with Rapid Apology and Remedy

Unexpected Event reported to Safety/Risk Management

Process Improvement

What’s wrong with this picture??????

Data Base

No

Patient Harm?

Yes

Consider “Second Patient” Error Investigation
Hold bills

Inappropriate Care?

Yes

Full Disclosure with Rapid Apology and Remedy

Unexpected Event reported to Safety/Risk Management

Process Improvement
After Telluride 2006

The Seven Pillars:
A Comprehensive Approach to the Prevention and Response to Patient Events

Data Base

Patient Communication Consult Service 24/7 Immediately Available

No

Patient Harm?

Yes

Unexpected Event reported to Safety/Risk Management

“Near misses”

Consider “Second Patient” Error Investigation Hold bills

Process Improvement

Activation of Crisis Management Team – emotional first aid

Inappropriate Care?

No

Full Disclosure with Rapid Apology and Remedy

© 2008 The Board of Trustees of the University of Illinois
ACGME New Program Requirements July 2011
Assessing safety and quality education…

The program director must ensure that residents:

- Participate in identifying system errors and implementing potential systems solutions.
- Work in inter-professional teams to enhance patient safety and improve patient care quality.
- Are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

New for 2013
CLER: Clinical Learning Environment Review

- The focus is now on the institution
- “responsibility of the sponsoring for the quality and safety of the environment for learning and patient care.”
New for 2013
CLER: Clinical Learning Environment Review

- Unannounced Site Visits
- Tracer methodology
- Six core areas
  - Patient safety – including opportunities for residents to report and participate in interprofessional teams
  - Quality – engage residents in use of data to improve, reduce disparities
  - Transitions of care
  - Supervision
  - Duties hours
  - Professionalism

The “Principled Approach” to Adverse Patient Events: the Core Competencies

Data Base

Patient Communication Consult Service

Patient Harm?

Consider "Second Patient"
Error Investigation
hold bills?

Unreasonable care?

Full Disclosure with Rapid Apology and Remedy

Near misses™

Activation of Crisis Management Team

Process Improvement

Concern, question or unexpected event reported to Safety/Risk Management

© 2008 The Board of Trustees of the University of Illinois
You cannot fix what you do not know about

Challenges to resident reporting

- Overcoming fears
  - Shame and blame
  - Angering supervisors, co-workers
  - Program punishment
- Establishing relevance
  - Reporter apathy – No feedback
    - Health system – no QI feedback for reporter
    - Individual – no learning for reporting
Addressing the challenges

- Provide method for safe, confidential reporting
- Ensure non-retribution to reporters
- Provide immediate educational feedback to learner (experiential – foundational and customized)
- Provide regular aggregated, de-identified educational feedback to hospitals, programs, reporters
- Link to quality and safety process improvements
- Also focus on important learner specific issues such as fatigue, supervision, hand-offs, professionalism.

Reporting

- Reporting established as an expectation and part of Core Competency assessment

The Resident Physician submitting this occurrence, MUST make sure you select your name for the field circled below. This will ensure that your Program Director receives the occurrence on his workload.

Please Note: This field is not mandatory so you will have to ensure that you capture your name in order to get credit.

After you submit your occurrence (Save), the occurrence will be populated on the Program Director’s workload, the Risk Manager.
An Assessment of an Educational Intervention on Resident Physician Attitudes, Knowledge, and Skills Related to Adverse Event Reporting

Resident physician occurrence reporting data

Journal of Graduate Medical Education, June 2010

© 2008 The Board of Trustees of the University of Illinois
Event data

<table>
<thead>
<tr>
<th>Category of occurrence</th>
<th>Number</th>
<th>Lack of adequate supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent/Documentation</td>
<td>3</td>
<td>2 of 3</td>
</tr>
<tr>
<td>Disruptive provider</td>
<td>7</td>
<td>0 of 7</td>
</tr>
<tr>
<td>Equipment</td>
<td>7</td>
<td>0 of 7</td>
</tr>
<tr>
<td>Patient fall</td>
<td>2</td>
<td>0 of 2</td>
</tr>
<tr>
<td>Lab specimen mismatched</td>
<td>2</td>
<td>0 of 2</td>
</tr>
<tr>
<td>OB anesthesia complications</td>
<td>3</td>
<td>0 of 3</td>
</tr>
<tr>
<td>Delay in treatment/service</td>
<td>8</td>
<td>0 of 8</td>
</tr>
<tr>
<td>Unplanned extubation</td>
<td>2</td>
<td>0 of 2</td>
</tr>
<tr>
<td>Patient transport issues</td>
<td>12</td>
<td>0 of 12</td>
</tr>
<tr>
<td>Treatment/procedure complications (intubation, regional block, central line placement)</td>
<td>17</td>
<td>9 of 17</td>
</tr>
<tr>
<td>Resident needlestick</td>
<td>2</td>
<td>0 of 3</td>
</tr>
</tbody>
</table>

Expanding the program

- Internal Medicine
- Pediatrics
- Emergency Medicine
- Radiology
- Urology
- Neurosurgery
- Obstetrics and Gynecology
- Pathology
Aggregate resident physician occurrence reporting data

The Seven Pillars:
A Comprehensive Approach to the Prevention and Response to Patient Events

- Data Base
- Unexpected Event reported to Safety/Risk Management
- "Near misses"
- Error Investigation
- Process Improvement
- Activation of Crisis Management Team – emotional first aid
- Full Disclosure with Rapid Apology and Remedy
- Inappropriate Care?
- Patient Harm?

© 2008 The Board of Trustees of the University of Illinois
Peer to peer support: for physicians by physicians

The Seven Pillars: A Comprehensive Approach to the Prevention and Response to Patient Events

1. Data Base
2. Unexpected Event reported to Safety/Risk Management
3. Process Improvement
4. Activation of Crisis Management Team – emotional first aid
5. Consider "Second Patient" Error Investigation
6. Full Disclosure with Rapid Apology and Remedy
7. Inappropriate Care?
   - Yes
     - Full Disclosure with Rapid Apology and Remedy
   - No
     - "Near misses"

© 2008 The Board of Trustees of the University of Illinois
Pillar 2 - investigation

- What happened and why?

---

High Reliability in Healthcare?

Healthcare, in contrast is an industry that has grown to expect and accept errors and patient harm as “normal”. It is considered an inherent risk that comes with the wonderful new advances that healthcare can offer its patients.
Human Factors Engineering and Safety

- Examples of Humans being Human:
  - Forgetting the gas cap on the top of your car (or even the gas hose)
  - Forgetting an ATM card at a teller machine
  - Construction crew forgot to return a mainline track switch back to the normal position after a day's work (NTSB, 2005)
  - Doctors forgot to logoff patient order entry system – patients receive wrong medications (Koppel et al., 2005)

Human Factor Issues in Healthcare
The Seven Pillars:
A Comprehensive Approach to the Prevention and Response to Patient Events

- Data Base
  - Yes
  - No

- Unexpected Event reported to Safety/Risk Management
  - Yes
  - Near misses

- Consider “Second Patient” Error Investigation
  - Inappropriate Care?
    - Yes
    - Full Disclosure with Rapid Apology and Remedy
    - No
    - Process Improvement

- Activation of Crisis Management Team – emotional first aid

Communication

- Timely
- Effective
- Coordinated
- Ongoing
- Engagement of highly competent communicators – case example
- Just in time support
- Interdisciplinary
Creating a communication consult service

- Communications assessment tool
- Measures emotional intelligence
- Assesses cognitive complexity
- Identifies highly skilled communicators in complex social situations
- Balances out the “special colleague” issue

Individual Differences in Communication Competence

- Some people are more skillful communicators than others.
- Some communication tasks/situations are much more difficult than others
  - Easy: describe your apartment
  - Hard: disclose a medical error to a grieving family
- Differences in skill most visible in hard situations
Benefits of Interpersonal Cognitive Complexity

- Same benefits as increased dimensional data, plus:
  - More organized and integrated impressions of others
  - Greater ability to:
    - recognize others feelings and dispositions; integrate inconsistent information about others; understand others thoughts, feelings and motivations; produce effective messages, accurately and completely interpret others messages, structure conversational interactions (Burleson & Waltman, 1988)

One hospital’s data

![Frequency Distribution of Number of Constructs (i.e. Cognitive Complexity)](chart.png)

- 4 standard deviations above the mean!
Putting it all together

Internet link
Elements of resolution/remediation

• Patient Safety Compensation Card – given to patients if harm caused by inappropriate care, serves as their ongoing “insurance card”

Putting it all together
http://www.youtube.com/watch?v=2h2Q_uTEckM

October 7, 2011

Family lends hand after deadly error
Another communicating openly and resolving early

Death gives new life to friend

ORGAN DONOR | Daughter dies in surgery, dad offers kidney to pal

BY PETE LENT

In death, Michelle Bohler has given new life to a lifelong friend in need of a second chance.

On Friday, Falk Fandel, kidney donor, was given in Lake County Medical Center to Michelle Bohler, who had been waiting for her kidney for two years. Falk is the daughter of former Illinois Mayor Robert Malcom.

Falk was always there to help everyone,” Malcom said. “Even if you wanted to help, and that’s why she’s a donor.”

Fandel, who had two daughters, died during a procedure at the University of Illinois Medical Center. Despite his grief, Malcom remembered his friend Ely, who needed a kidney, he called him.

“Ely knew what was the right thing to do.”

© 2008 The Board of Trustees of the University of Illinois

October 7, 2011

Medical mistake spurs relatives to join hospital panel, not sue

© 2008 The Board of Trustees of the University of Illinois
Pillar 6 - data
Other data update

- Medical Malpractice Premium data
- Overall reduction on premium over past three years = $22MM
- FY 11 - $4.7MM less than FY 10
- FY 12 - $7.4 MM less than FY 10
- FY 13 - $10.1MM less than FY 10
- 2006 – SIP $45MM underfunded
- 2012 – SIP $8MM in excess
Other stakeholder buy-in prior to grant

- Medical Societies
- Professional liability companies – hospital and physician
- Hospital Association
- Legal groups
- Consumers Advancing Patient Safety
- Project Patient Care
- Individual hospital boards, medical staffs

AHRQ Grant

- 10 private hospitals, self insured
- Open medical staffs, private professional liability coverage
- 7 from faith-based system
- 2 from a “for profit”
- 1 underserved inner city
- Most with resident physicians
Data from one grant hospital

- Large reduction in serious reportable events
- Already experiencing reduction in liability claims

Next steps

- AHRQ Task Order
Next steps

- AHRQ Task Order
- Create comprehensive set of validated and tested tools to facilitate the implementation of the Seven Pillars across all hospitals

Agency for Healthcare Research and Quality announcement this week
Questions?