Communication to Prevent and Respond to Medical Injuries: WA State Collaborative

Thomas H. Gallagher, MD
Professor of Medicine, Bioethics & Humanities
Director, UW Medicine Center for Scholarship in Patient Care Quality and Safety
Director, Program in Hospital Medicine
University of Washington

Background

• Medical injuries common
• Poor team communication as cause of many injuries
• Communication with patient often deficient in response to injuries
  • Disclosure often fails to meet patient expectations
  • Difficult for injured patients to receive fast, fair compensation
Project Overview

• Created HealthPact Forum
  • Ongoing engagement with trial attorneys, regulators among other stakeholders
• Communication training
  • Team Communication Training
  • Disclosure and Apology Coach Training
• Created and piloting the Disclosure and Resolution Program (DRP)

What is the DRP?

• Be candid and transparent about unanticipated care outcomes
• Conduct a rapid investigation, offer a full explanation, and apologize as appropriate
• Where appropriate, provide for the family’s financial needs without requiring recourse to litigation
• Build systematic patient safety analysis and improvement into risk management
HealthPact DRP Demonstration

- Motivating question: Can DRP work as well...
  - ... outside a closed system?
  - ... when multiple insurers are involved?
- Our Project: Collaboration between PI and 6 Partner organizations on:
  - Event investigation
  - Disclosure to patient
  - Incident resolution, including compensation offer when appropriate

DRP Partners

- Physicians Insurance A Mutual Company
- Providence Sacred Heart Medical Center and Children’s Hospital
- Providence Regional Medical Center, Everett
- Providence St. Mary Medical Center
- The Everett Clinic
- The PolyClinic
- The Vancouver Clinic
DRP Events

- DRP study events: Unanticipated, adverse outcomes of care (from perspective of patient, provider, or institution)
- Many unanticipated outcomes are not caused by health care
  - Disease progression, unmet expectations
- Some unanticipated outcomes may be “adverse events” (harm due to health care)
  - Some adverse events may be associated with care that was not reasonable under the circumstances
- Effective communication with patients important for all unanticipated outcomes

Disclosure and Resolution Program Process

- Care team responds to immediate patient needs and provides information then known
- Involved staff reports SE to Risk Manager
Disclosure and Resolution Program Process

Action by Facility Risk Manager

- Initiates QI investigation using Just Culture approach
- Initiates support services for patient/family
- Initiates disclosure coaching and other support services for healthcare team
- Contacts other Partners to explain SE and steps taken and initiates collaboration

Physicians Insurance
Facility Insurer
Other Insurer

Partners collaborate on approach to evaluation and resolution
Disclosure and Resolution Program Process

Partners and involved providers decide on effective approach and timeline for CARE, including internal and/or external expert review to determine:

- Whether care was reasonable
- Whether system improvements are needed to prevent recurrence
- Whether other actions are warranted

Partners agree on approach to resolution:

- What are the patient’s/family’s needs?
- Will monetary compensation or other remedies be offered?
- What will be disclosed to patient/family?
- How will identified system improvements be pursued?
Disclosure and Resolution Program Process

Study Event (SE) → Action by Facility Risk Manager → Physicians Insurance → Joint Approach to Resolution → Expedited Care Assessment and Review of Event (CARE) → Patient/Family Communication

Patient/family is notified of findings and approach to resolution:
• Full explanation of what happened
• Apology as appropriate
• Offer of compensation and/or other remedies, or explanation of why no offer is being made
• Information about any safety improvements

The DRP is not:
• A rush to judgment
• A rush to settlement
• Mandatory
• Telling the patient absolutely everything known about an adverse event
• Paying patients when care was reasonable
• Business as usual
Lessons learned to date

• Diverse stakeholders will collaborate around improving the response to medical injury
• Communication training to prevent and respond to injuries widely disseminated
• Healthcare institutions embrace DRP in concept, experience challenges with implementation (especially in shared cases), hesitant to take time for evaluation.

Challenges of collaborative DRP cases

• How do stakeholders for every case:
  • Alert one another a shared event has occurred?
  • Share information about the event without causing HIPPA issues?
  • Share experts?
  • Deal with disagreements among stakeholders
  • Get consent to settle from physicians?
• Joint defense agreements?
DRP Implementation Barriers

- Lack of uniform application to all unanticipated outcomes
- Physician fear of adverse event reporting
- Lack of trust among key stakeholders
- Time constraints for quality/safety/risk leaders
- Physician concern about NPDB, MQAC, peer review

DRP Certification Concept

- Provider fear is deterrent to early event reporting
- Hard to ensure learning after adverse events
- Early collaboration with MQAC around concept for “DRP Certification” to promote patient safety
  - for those events being handled through DRP Process:
    - MQAC would agree to put investigation on hold
    - If at conclusion of DRP process event meets criteria for DRP Certification, MQAC would likely close case
    - Cases of unprofessional conduct, willful or reckless conduct are not eligible for DRP certification
- Process would be available to all Washington physicians.
- Long term vision-create WPHP-like program for handling medical error