Communicating with Patients and Colleagues After Harm Events:

A Quality and Safety Imperative All Nurses Should Know

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Learning Objectives

By the end of this webinar, participants should be able to:

1. Understand the critical role that Communication and Resolution Programs (CRP) play in promoting quality and safety as well as reducing the suffering of patients, families, and clinicians after harm events
2. List the core elements in the CRP process and why they matter
3. Identify strategies and practical skills for communicating with patients and with colleagues after harm events

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"Listen up, my fine people, and I'll sing you a song 'bout a brave neurosurgeon who done something wrong."

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Case Example One

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Delayed Diagnosis of Cancer Case

Dr. Buckley is seeing Mary McCarthy, who was recently diagnosed with breast cancer and has begun treatment. She had reported a breast lump to her PCP, Dr. Bloom. Dr. Bloom noted a cystic area that was not different from the rest of the breast tissue. Since MM was near the start of her menstrual cycle, Dr. Bloom recommended she be reexamined. Dr. Bloom then went on leave, and Dr. Buckley assumed her care. MM saw Dr. Buckley several times for high blood pressure but did not mention the breast lump and Dr. Buckley did not notice this problem in her chart. Six months later, her blood pressure now under control, MM mentions the breast lump to Dr. Buckley and notes it is getting bigger. Dr. Buckley is surprised and did not know this was an issue. The patient was subsequently diagnosed with cancer and has returned to discuss these events with Dr. Buckley.

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Reflecting on this Video

- What did this clinician do that was effective?
- What opportunities for improvement did you notice?

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CRP Overview and Steps in the CRP Process

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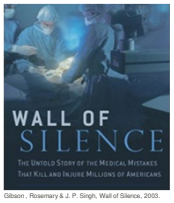
Following Harm:
Not Always Transparent, Not Always Learning

HealthAffairs
February 2012

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



Gibson , Rosemary & J. P. Singh, Wall of Silence, 2003.

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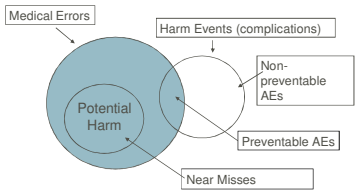
Lisa I Iezzoni , Sowmya R Rao, Catherine M DesRoches, Christine Vogeli, Eric G Campbell; CANDOR 9

Relationship of Errors and Harm Events



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Transparency: A Precondition to a Culture of Safety in Medicine

- A practiced value in everything we do
- The most important characteristic of a safe and reliable culture
- Essential for learning and improvement

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Five Areas of Transparency

01	02	03	04	05
With Colleagues	With Patients and Families	With the Organization	Between Organizations	With the Public

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Why Do We Struggle to Respond to Harm Events?

- Human nature to want to keep problems to ourselves, to avoid difficult discussions
- Fear of punitive consequences, shame/ embarrassment, lack of skills
- Mixed messages from institutions
- Different elements of response not integrated and hard-wired

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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

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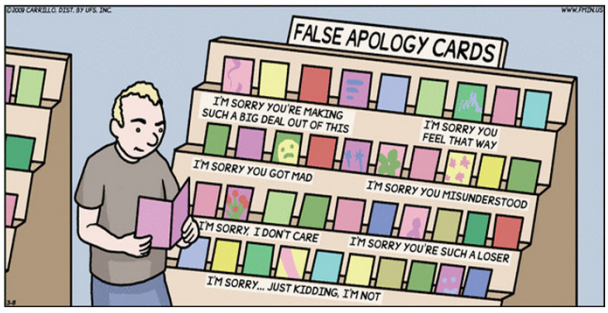
May T, Aulisio MP. Kennedy Inst Ethics J. 2001; 11(2):135-146 14



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What is a CRP

- Communication and Resolution Programs (CRPs) are:
  - Comprehensive
  - Principled
  - Systematic
- Seek to prevent and respond to adverse events

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Elements of a CRP Response

	Traditional Response	CRP Response
Incident reporting by clinicians	Delayed, often absent	Immediate
Communication with patient, family	Deny/defend	Transparent, ongoing
Event analysis	Physician, nurse are root cause	Focus on Just Culture, system, human factors
Quality improvement	Provider training	Drive value through system solutions, disseminated learning
Financial resolution	Only if family prevails on a malpractice claim	Proactively address patient/family needs
Care for the caregivers	None	Offered immediately
Patient, family involvement	Little to none	Extensive and ongoing

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Moving Away from "Error Disclosure"

- Field has shifted to focus on:
  - Harm communication (for both preventable and non-preventable harm events)
    - Within a broader, integrated program for identifying and responding to harm (CRPs)
      - As integral to the clinic mission, rather than a risk management activity
        - Supported by tools and resources to ensure high reliability

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Important Developments in the CRP Field

- Just Culture recognized as foundational facilitator of improving quality, safety, and accountability
- CRP recognized as quality and safety, not risk management, activity
- Expansion from large, self-insured AMCs to diverse practice environments
- Response to harm as team sport

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Nursing Attitudes About Harm Communication

- Strongly support being open with patients after harm and want to participate in these discussions
  - See these as team discussions, consider them to be difficult conversations
  - Want to participate, often feel excluded
  - Concerned that if not present when harm discussed with patient, they may get blamed
- "Walking on eggshells"

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Shannon SE et al, Joint Commission Journal on Quality and Patient Safety. 2009;35:5-12. 20

Communication and Resolution: A Reflection from the Field

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22

BIDMC's Approach to Preventable Harm
Setting an Aspirational Goal

In 2007 we aimed to:

"eliminate preventable harm by January 1, 2012"

Preventable: standard of care was not met, or there are reasonable improvements that would decrease the likelihood of a similar future event

Spoiler alert…

…we didn't get to zero!

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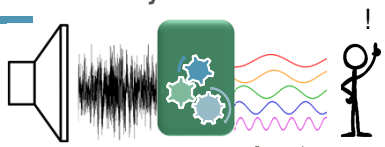
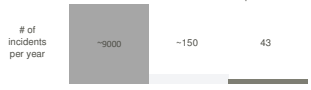
Experience with Physical Harm





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Considerations

- Mission statement & values
  - Patient-centered care, respect, dignity, equity
- Senior leaders pursue high-reliability & aim to eliminate preventable harm
- Senior leaders support the people, processes, and systems that enable routine and constructive discussions about patient safety events
- Risk management, patient safety & patient relations coordinate after adverse events
  - Regardless of whether an error occurred, proactive communication with the patient/family is encouraged
- Quality-safety professionals use RCA², and Fair & Just Culture principles
- Structures/systems support professionals' physical and psychological safety
  - Peer support program
- Patient-family engagement supported by people and processes

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It Seems So Simple……

- **Communicate** with patients and families when unanticipated adverse outcomes occur and provide for their immediate needs
- **Investigate and explain** what happened
- Implement systems to **avoid recurrences** of incidents and improve patient safety
- Where appropriate, **apologize** and work towards **resolution** including an offer of fair compensation without the patient having to file a lawsuit

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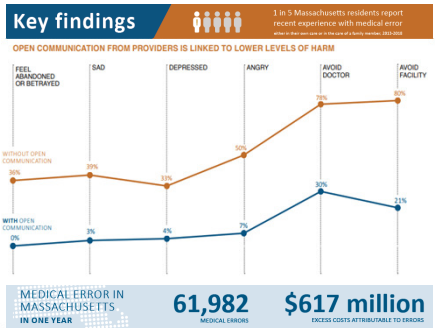

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Barriers to CARe Implementation

Barrier*	# of Respondents
Charitable immunity law	22
Physician discomfort with disclosure & apology	21
Attorneys' interest in maintaining the status quo	20
Coordination across insurers	20
NPDB or state reporting requirements	19
Concern about increased liability risk	16
Forces of inertia	13
Fairness to patients	12
May not work in other settings	11
Insufficient evidence	8
Supporting legislation	8
Accountability for the process	5

** Other barriers, not listed, were mentioned by <4 respondents*

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Educating Clinicians – Steps following an Adverse event

Step 1: Report the event and get help with communication (Pager system/Reporting System/Call)

Step 2: Communicate with the patient/family about the event; be empathetic and use statements of regret ("I am so sorry this happened to you…"); discuss facts known at this time and do not speculate or blame others.

A note on Apology:

1. Statements of Regret – **Always!**
2. Apology of Fault – **Once facts are known** (if applicable)

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Educating Clinicians – Steps following an Adverse event

Step 3: Document the communication with the patient/family in the record; facts, who was present, and results of conversation.

Step 4: Check back in with the patient/family and discuss with them the findings and any systemic improvements to be made once all facts are known and root causes have been determined.

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Measuring Outcomes……

1. Did the implementing hospitals stick to CARe protocol?
2. How often did CARe events require compensation offers?
3. Did using CARe have an effect on costs, claims, or resolution time?
4. How did involved providers respond?
5. What success factors were identified?

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Areas of Investigation - Massachusetts

Data Collected	Outcomes
• Institution-level data on volume and costs of claims and lawsuits • Case-specific data for each adverse event that meets study criteria • Survey of providers involved in a CARe case • Interviews with key personnel • Monthly pilot site check-in calls	1. Institutional liability outcomes 2. Case level outcomes 3. Provider Satisfaction with CARe 4. CARe implementation experiences

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The Massachusetts Pilot Sites

Site	#Beds	Location	Teaching (Y/N)
Beth Israel Deaconess Medical Center	642	Urban	Y
BID-Milton	88	Community	N
BID-Needham	58	Community	N
Baystate Medical Center	716	Urban	Y
Baystate Franklin Medical Center	93	Community	N
Baystate Mary Lane Hospital	31	Community	N

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Conclusions

- CARe does not lead to an avalanche of new claims or require many cases to be sent to insurer
- Resolved cases were settled with median payment of $75K (compensation in < 5% of CARe cases); only 9% resulted in compensation
- Most of the work of CARe is communicating about non-error events

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Results: Were there any statistically significant changes ($p \leq 0.05$) in liability trends?

Outcome	CARe CRP Hospitals	Comparison Hospitals (No CRP)
New claims	Lower at community hospitals and 1 academic medical center	No change
Defense costs	Lower at both academic medical centers	No change
New claims receiving compensation	No change	No change
Compensation costs	No change	No change
Average payment per claim	No change	No change
Time to resolution	No change	No change

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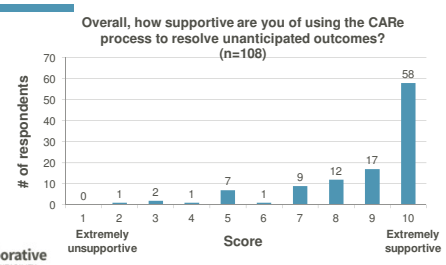
35

Providers are Supportive of CARe Overall



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74 respondents said they did not know enough to answer this question.

36

Implementation Lessons Learned

- Consistency
  - Rigor in the CARe process for all adverse events is essential to the success of the program – *including* those events which were unavoidable complications.
- Leadership
  - Leadership must be on board, and continuously advocate, especially when it's the hard thing to do
- Teamwork
  - CARe works best when risk management and patient relations communicate and work together well

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Lessons Learned (Continued)

- Support
  - Providers (clinician peer support; help understanding CARe)
  - Patients (Patient Relations; MITSS; social work; help understanding CARe)
- Reinforcement
  - Re-education and reaffirming the CARe process throughout the institution helps to make a cultural change
    - M&Ms, QI Directors, Grand Rounds

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Factors Facilitating Successful Implementation

- Deep engagement by high-level physician champions
- Strong buy-in from risk management
- Practical support and oversight by project managers
- **No barriers erected by malpractice insurer**
- Pre-existing just culture commitment
- Sense of community and support from MACRMI

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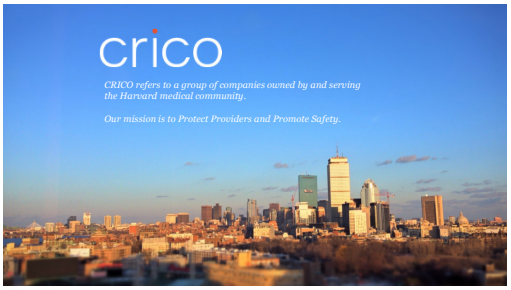

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CRICO
Controlled Risk Insurance Company

- A patient safety and medical malpractice company owned by and serving the Harvard medical community since 1976
- CRICO insures:
  - 16,600 physicians (including 4,000 residents and fellows)
  - 35 hospitals
  - 140,000+ employees (nurses, advanced practice registered nurses, physician assistants, technicians, etc.)
- Coverage follows a physician regardless of location or site of care
- Provides coverage for professional liability (medical malpractice), employment practice liability, general liability, and international MPL

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Our Members

- **Atrius Health**
- **Boston Children's Hospital**
  - Boston Children's Health Physicians
- **Cambridge Health Alliance**
- **Beth Israel Lahey Health**
  - Addison Gilbert
  - Anna Jaques Hospital
  - Bayridge
  - Beverly Hospital
  - Beth Israel Deaconess Medical Center
  - Beth Israel Deaconess Hospital—Milton
  - Beth Israel Deaconess Hospital—Needham
  - Beth Israel Deaconess Hospital—Plymouth
  - Joslin Diabetes Center
  - Lahey Hospital and Medical Center
  - Mount Auburn Hospital
  - New England Baptist Hospital
  - Winchester Hospital
- **Dana-Farber Cancer Institute**
- **Judge Baker Children's Center**
- **Massachusetts Institute of Technology**
- **Mass General Brigham**
  - Brigham and Women's Hospital
  - Brigham and Women's Faulkner Hospital
  - Cooley Dickinson
  - Dana-Farber Cancer Institute
  - Martha's Vineyard Hospital
  - Massachusetts General Hospital
  - Massachusetts Eye & Ear Infirmary
  - McLean Hospital
  - Nantucket Cottage Hospital
  - Newton-Wellesley Hospital
  - North Shore Medical Center
  - Spaulding Rehabilitation Hospital
  - Wentworth Douglass Hospital
- **Presidents & Fellows of Harvard College**
  - Harvard Medical School
  - Harvard School of Dental Medicine
  - Harvard School of Public Health
  - Harvard University Health Services

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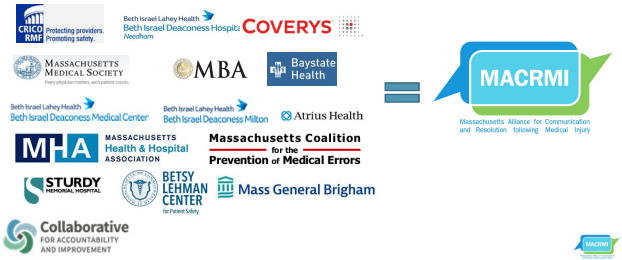
42

Massachusetts Alliance for Communication and Resolution following Medical Injury



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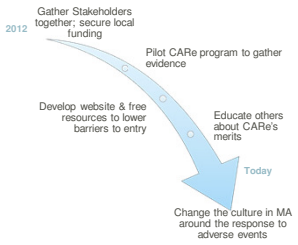
MACRMI's Journey



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Publications

- Data addressing success factors, just released: https://qualitysafety.bmj.com/content/early/2020/01/20/bmjqs-2019-010296.long
- Data addressing costs, claim numbers, and time to resolution, published November 2018: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0720?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossr ef.org&rfr_dat=cr_pub%3Dpubmed
- Data addressing claims numbers, provider satisfaction, and adherence published in Health Affairs in 2017: http://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0320
- Data regarding patients and medical error in Massachusetts: https://www.betsylehmancenterma.gov/research/costofme

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Case Example Two: Communication Skills

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Desired State: Shortly After a Harm Event Occurs

- Patients are:
  - Alerted to what happened
  - Have their immediate medical and social needs addressed
  - Given regular updates on material facts about the event, how clinical consequences are being addressed, plans to prevent recurrences
  - Informed about what the organization's approach is to supporting patients after harm events and what to expect going forward
  - Given emotional support, including apology
  - Encouraged to ask questions and receive timely responses
  - Provided consistent messages from all the clinicians caring for them
  - Supported in ways that meet their individual needs
- Involved clinicians received effective peer support

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Delayed Diagnosis of Cancer Case

Dr. Buckley is seeing Mary McCarthy, who was recently diagnosed with breast cancer and has begun treatment. She had reported a breast lump to her PCP, Dr. Bloom. Dr. Bloom noted a cystic area that was not different from the rest of the breast tissue. Since MM was near the start of her menstrual cycle, Dr. Bloom recommended she be reexamined. Dr. Bloom then went on leave, and Dr. Buckley assumed her care. MM saw Dr. Buckley several times for high blood pressure but did not mention the breast lump and Dr. Buckley did not notice this problem in her chart. Six months later, her blood pressure now under control, MM mentions the breast lump to Dr. Buckley and notes it is getting bigger. Dr. Buckley is surprised and did not know this was an issue. The patient was subsequently diagnosed with cancer and has returned to discuss these events with Dr. Buckley.

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Reflecting on this Video

- What did this clinician do that was effective?
- What opportunities for improvement did you notice?

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Harm 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

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Biggest Mistake When Discussing Harm Events with Patients is…

Lack of planning and preparation for discussion

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Key Harm Communication Planning Skills

- Solicit team members' views
- Plan roles for discussion
- Advocate for transparency
- Anticipate patient questions
- Avoid jargon, blame

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What Does the Patient Want? Empathy

- They want to be heard. They won't listen until they are heard. Recognize and validate the emotion first.
- Curiosity
- What skill accomplishes that?
- Reflective listening is not intuitive – Why?

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There's no easy way I can tell you this –
so I'm sending you to somebody who can…

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What Does the Future Hold?

- Creating highly reliable CRP programs
  - Measures to assess fidelity to CRP principles
    - Guide internal improvement and external accountability
- Continued stakeholder engagement with liability insurers, attorneys, regulators (especially state boards), patient advocates
- Next-generation peer review

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How the Nursing Profession Can Be Involved

Group	Key next steps
Bedside nurses	• Embrace the key role transparency plays in reducing and responding to harm events • Learn about local resources to support the response to harm events.
Advanced Practice Providers	• Practice skills for communicating with patients, colleagues about harm events
Nursing leaders within healthcare organizations	• Ensure CRP programs at their institutions integrate the nursing perspective • Support practitioners in receiving basic training in responding to harm events effectively
State boards of nursing	• Recognize Just Culture principles for responding to harm events • Identify key CRP behaviors as potentially mitigating factors when reviewing complaints
Nursing certifying boards	• Incorporate CRP concepts and content into certifying exams and MOC programs

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Advancing Quality, Safety, and Professionalism Through CRPs

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A CRP E-Learning Module for Certifying Boards: Goals

- Provide valuable knowledge and practical skills to nurses
- Elevate the importance of CRPs to all nurses by having certifying boards define CRPs as a critical component of their ongoing education
- Spread the use of CRPs to avoid harm events, and, when harm events occur, to respond in ways that preserve patient and family satisfaction, enhance quality and safety, and reduce adverse consequences for nurses
- Employ engaging question formats and tailored content (sample questions on the following slides)

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Case Introduction

You are a primary care physician in a large multi-specialty practice. You have been covering for your colleague Dr. Rogers who was on medical leave the last year. You have been following one of his patients, Stella McCarthy, a middle-aged woman who saw you three times for refractory hypertension. At her most recent visit, she mentioned that the breast lump she had shown to Dr. Rogers 18 months ago was not any better and in fact had grown. On your physical exam you felt a worrisome lump and sent her for imaging. A biopsy was done which revealed cancer, and Miss McCarthy is waiting to consult with a breast surgeon about next steps. You look back at Miss McCarthy's electronic medical record and note that she indeed brought up this lump to Dr. Rogers 18 months ago. She was near the start of her menstrual cycle, so Dr. Rogers recommended the patient return for re-examination. The patient did not make a follow-up appointment for this issue, and Dr. Rogers did not document a possible breast lump on the patient's problem list. The practice had adopted a new EHR around that time and many physicians had not received training on using it to track unconfirmed diagnoses. Dr. Rogers has returned but is slowly ramping up his practice so has not yet taken over the care of Miss McCarthy.

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Write In Your Response

You see Dr. Rogers in the hall, and mention what happened. He notes

What would you say next to Dr. Rogers? (write in your response)

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Pre-Written Response Options and Critiques

A. "*We're all doing our best, and some bad outcomes are unavoidable when patients don't follow advice*"
   i. This creates alignment with Dr. Rogers and emotional support. However, it avoids meaningful discussion about the medical error and will deter planning for disclosure if the assumption is that the outcome is solely the patient's fault.

B. "*Regardless of the cause, the important thing now is that we get her the best cancer care possible. I've set up an urgent appointment with a surgeon, can you place an oncology referral?*"
   i. This response focuses on providing the best care going forward, which is an important goal. It also does not endorse Dr. Rogers' claim that the patient is to blame. However, it avoids necessary discussion about reporting, understanding the causes, and preparing for disclosure.

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Response Options and Critiques (Cont.)

C. "*That sounds like blaming the patient when a big factor is what you forgot to do. You need to step up and take some accountability here.*"
   i. This response addresses physician accountability and counters the mistaken assumption that this was strictly the patient's fault. However, the accusatory tone will erode the safe and just environment required to investigate errors. This confrontation will also deter collaboration in disclosure to the patient.

D. "*It sure can be hard to hear news like this – it hurts to hear one of our patients developed a serious disease. I share your frustration with the delayed diagnosis and wish she had seen you in follow-up, but I don't want to assume anything about her reasons just yet. Also, I wonder what we could have done differently on our side. Maybe we can learn something from this to help other patients like her?*"
   i. This response validates some of the emotions Dr. Rogers is feeling without transferring blame to the patient. It also invokes accountability without shaming Dr. Rogers, which opens the door for collaboration around reporting and disclosure.

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Video Response Options

You provide Ms. McCarthy a basic explanation of how this sequence of events unfolded. She responds:

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Video Response Options

What would you say next?

A. "I think if we can get you set up to see the oncologist right away, you will feel much better. My colleague Dr. Smith is an expert in just this type of cancer—I know you'll really love her."

B. "Try not to worry. I'm confident we can get you through this. You'll see, everything will be just fine."

C. "I can only imagine how scary this must be for you. What is the most upsetting part of this for you right now?"

If you choose the answer A, you will receive the video response from a patient on the following slide

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Ms. McCarthy's Response to Option A

"I think if we can get you set up to see the oncologist right away, you will feel much better. My colleague Dr. Smith is an expert in just this type of cancer—I know you'll really love her."

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Option A Written Commentary

- While it is natural to want to offer reassurance, doing so prematurely may convey the wrong message. As this video illustrates, offering reassurance before eliciting the patient's experience and understanding the full impact of the event from the patient's point of view is likely to be counterproductive. Patients want providers to understand and appreciate what they have been through, and how it has affected them. This includes but goes beyond understanding the impact on their health. Once this understanding is established and conveyed, the patient will be more receptive to discussing next steps.

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The PACT Collaborative

Pathway to Accountability, Compassion, and Transparency

Creating Highly Reliable Communication & Resolution Programs

This program presented by:

ARIADNE LABS | Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT | Institute for Healthcare Improvement

68

The PACT Collaborative Launched this Week!

A learning community dedicated to helping organizations achieve highly reliable CRPs

- Breakthrough Series Collaborative Structure:
  - Five learning sessions
  - Action Periods with coaching from nationally recognized experts, regular check-ins, a community forum for support, and data submission with automatically generated reports
- Best practices presented in a structured 18-month curriculum
- Innovative suite of tools and resources
- Highly collaborative core teams that include nurses, clinician champions, patient and family representative, patient safety officers and more

69

PACT Participants

- Beaumont Health (2)
- CommonSpirit (2) & Virginia Mason
- Christiana Care
- Confluence Health
- Dartmouth Hitchcock Medical Center
- DHS LA County (2)
- Hartford Health
- Hendrick Health (2)
- Johns Hopkins
- Kaiser Permanente WA
- MedStar (2)
- Multicare (10)
- Providence Health System (4)
- Seattle Cancer Care Alliance
- Seattle Children's Hospital
- The Clare
- University of Washington (3)
- University of Minnesota Physicians
- Yale New Haven Hospital

70

Email thecai@uw.edu to learn more and get your organization on the list for PACT 2.0

71

Summary

- Transparency is a vital part of our professional role and is essential to the clinical mission
  - But does not come naturally to us
- Transparency involves an interprofessional, disciplined, and proactive approach to communicating after harm with patients/families, colleagues, and healthcare organizations
- Communication and Resolution Programs facilitate a principled and highly reliable response to communicating with patients/families after harm events

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72

Questions?

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74