MedStar Health
Institute for Quality and Safety

Knowledge and Compassion
Focused on You

January 20, 2017

When words and actions matter most:
The Case for CANDOR

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Beazley Institute for Health Law and Policy

No conflicts

Objectives

By the end of the presentation the participants will be able to:

- 1. List the benefits of a comprehensive response to patient harm that includes open and honest communication.
- 2. Describe the importance of a proactive "care for the caregiver" program in maintaining staff engagement and wellness.
- 3. Understand the benefits that accrue from a Just Culture and Human Factors based approach to unexpected patient harm events.

Goals of a Communication and Optimal Resolution [CANDOR] Process

- Reduce harm thru transparency and learning
- Reduce legal involvement through early, effective communication with all parties
- Resolve inappropriate care cases early, efficiently
- Support patient and family engagement
- Support care professionals following harm events

Malizzo Family Video

The path from 1982 to the Malizzo family

Overview of Patient Safety

- April 22, 1982 ABC 20/20 show: “The Deep Sleep – 6,000 will die or suffer brain damage…from carelessness”

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"If you are going to go into anesthesia, you are going on a long trip and you should not do it, if you can avoid it in any way. General anesthesia is safe most of the time, but there are dangers from human error, carelessness and a critical shortage of anesthesiologists. This year, 6,000 patients will die or suffer brain damage. . . . The people you have just seen are tragic victims of a danger they never knew existed—mistakes in administering anesthesia."

Overview of Patient Safety and Anesthesiology

- 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

Overview of Patient Safety and Anesthesiology

- Following the Human Factors Analysis of Harm Events along with closed-claims analysis and the redesign of care delivery
- 1982 to the present:

Overview of Patient Safety and Anesthesiology

- Following the Human Factors Analysis of Harm Events
- 1986 New Monitoring Standards Initiated
- Anesthesia Mortality Risk
  - 1982 - 1:2000
  - 2012 – 1:400,000
  - Substantial reduction in patients and families seeking legal action

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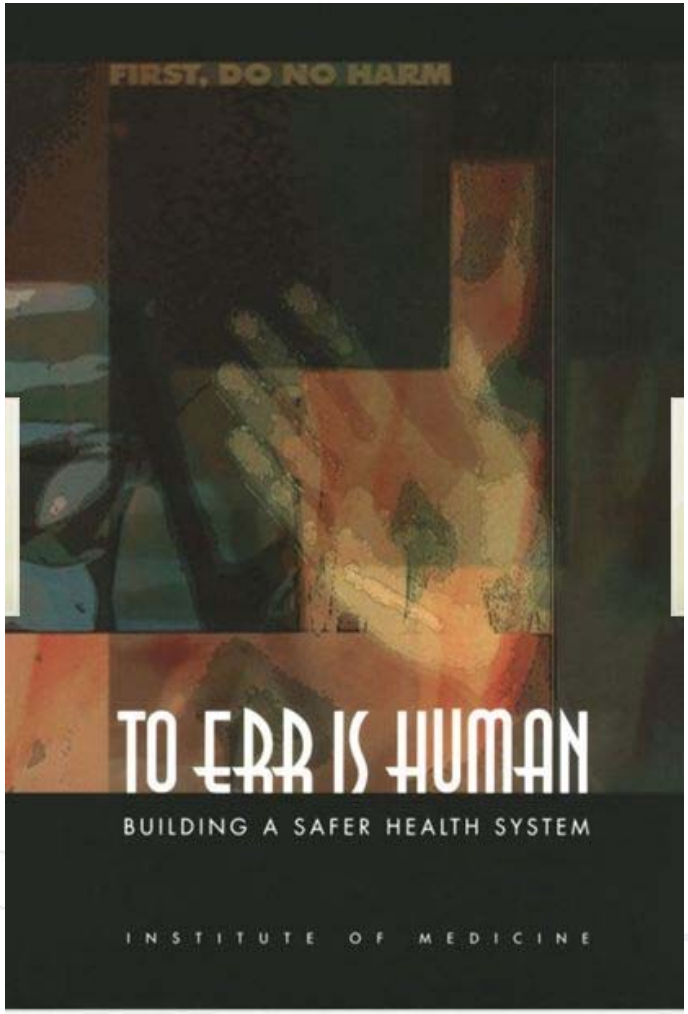
  - Why?

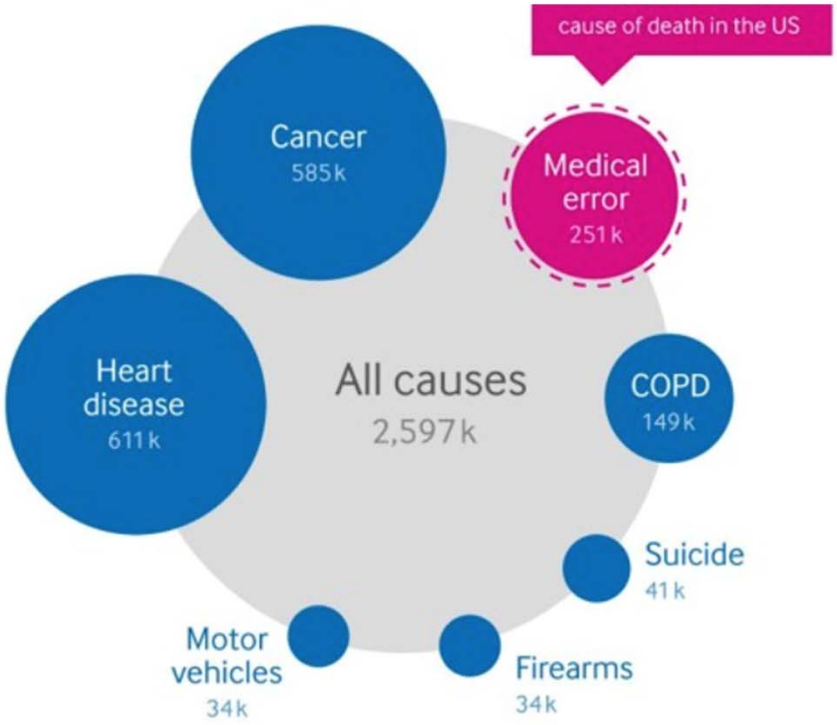


Institute of Medicine: 1999 report that started the patient safety movement

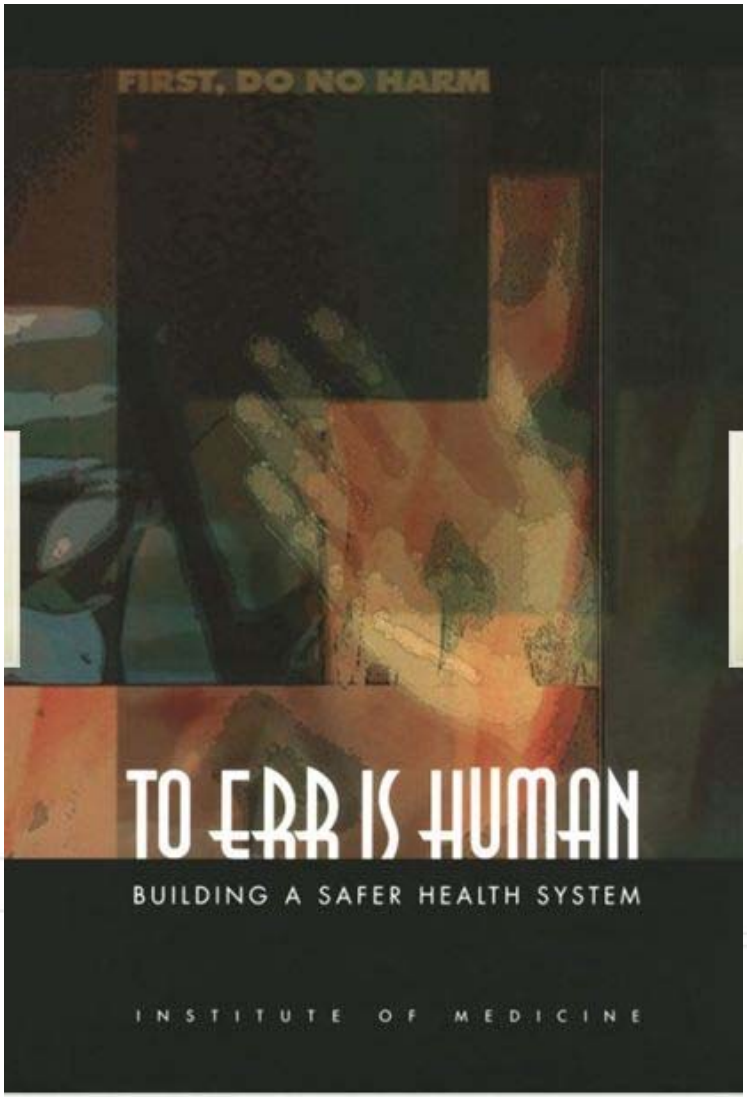
The Problem: restated

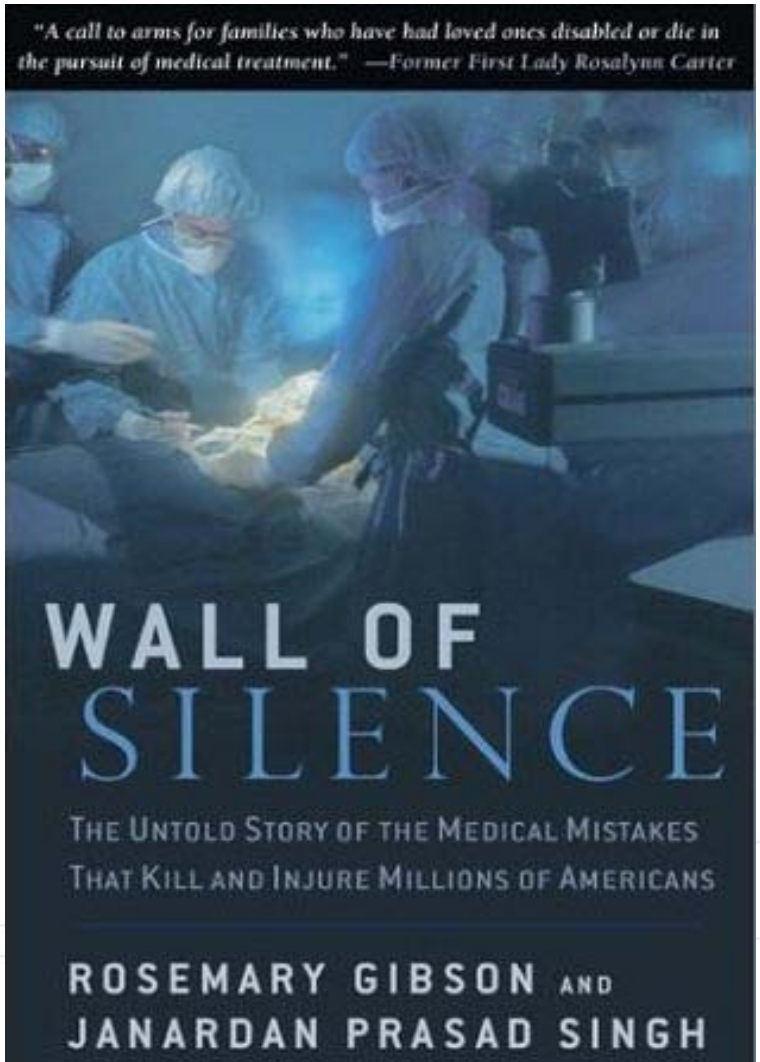
Makary and Daniel *BMJ 2016; 352:i2139*

Researchers: Medical errors now third leading cause of death in United States



Making matters worse





Part of the patient safety problem

HealthAffairs

February 2012, Volume 31, Issue 2

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

Expand

Lisa I. Iezzoni[1,*], Sowmya R. Rao[2], Catherine M. DesRoches[3], Christine Vogeli[4] and Eric G. Campbell[5]

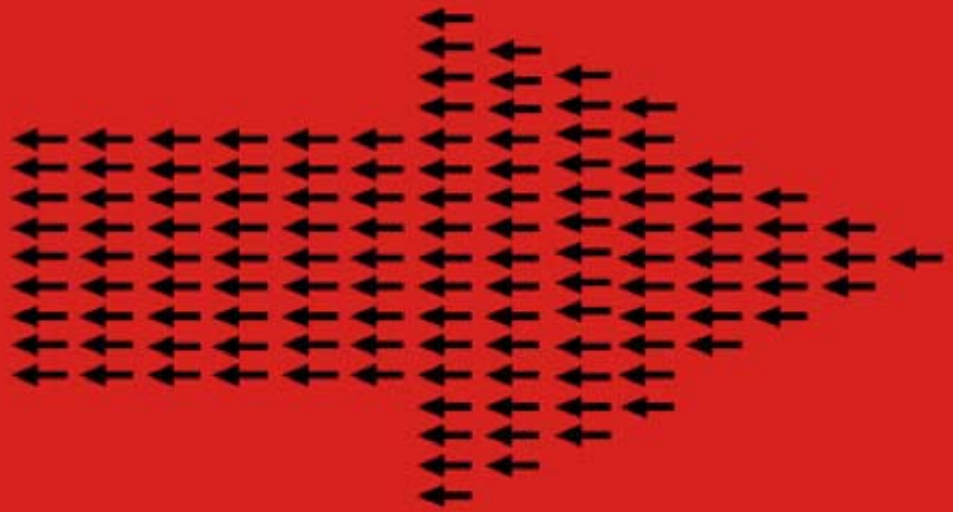
Legal community perception of Health Affairs article

Alan D. Bell *Attorney at Law*

Certified by the Supreme Court of New Jersey as a Civil Trial Attorney

Study says your doctor may not always tell you the whole truth

Culture eats strategy for breakfast



Until 2003 we had a sturdy wall of silence

- COO of sister hospital
- Came to the University for plastic surgery
- Abnormal WBC count – missed

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- We said nothing to fiance or other family members
- We litigated for years, paid millions, learned little

- Barriers
- Benefits

What about CANDOR

- Barriers
  - Lack of skill
  - Loss of job
  - Reputation
  - "Shame and blame"
  - Loss of control
  - Loss of license, deportation
  - Fear of lawyers, legal system
  - Non-standard process
  - Money
- Benefits
  - Maintain trust
  - Learn from mistakes
  - Improve patient safety
  - Employee morale
  - Psychological well-being
  - Accountability
  - Money
  - Less legal involvement

So, how did we shatter the wall of silence?

2005 Leaders at the University approved:

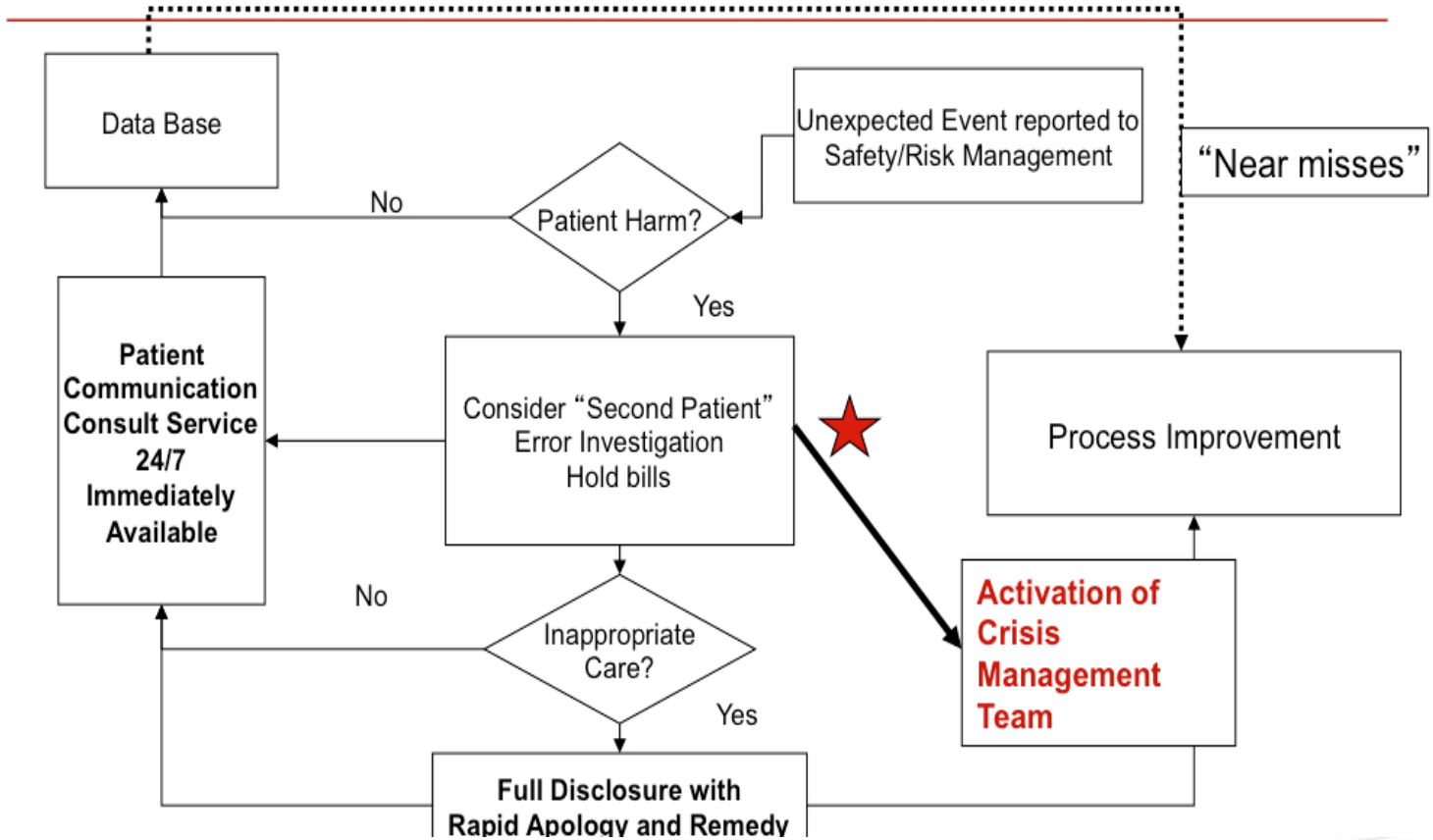
Comprehensive "communication- resolution" program to prevent and respond to harm – a CANDOR process

- Created urgency
- Comprehensive – with leadership and stakeholder buy-in
- Integrate safety, risk, quality, credentialing, claims and the Office of Business and Finance
- Linking transparency to learning: patient safety education plan
- Agreement to shift the paradigm for response to harm
- Started small
- Celebrated wins
- Continuous Rapid Process Improvement

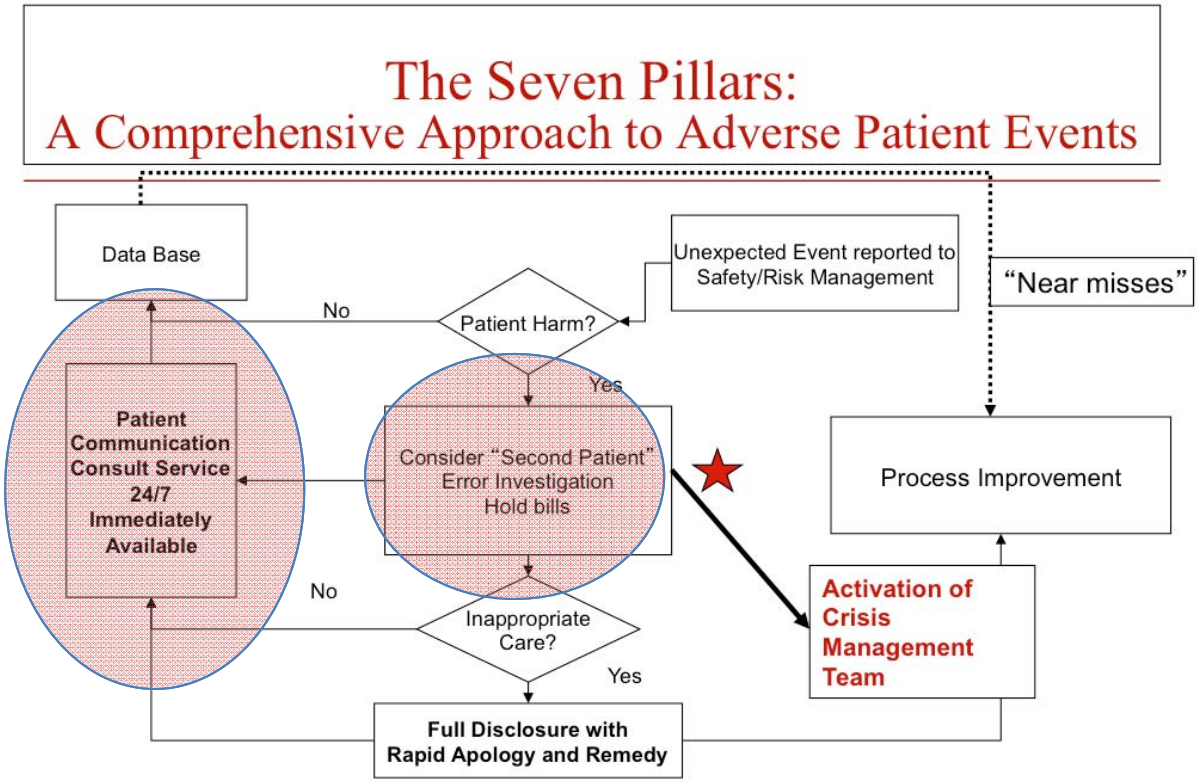
Changes needed to our response to harm in 1999

Paradigm Shift	Traditional Response	Communication and Optimal Resolution (CANDOR) Process
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

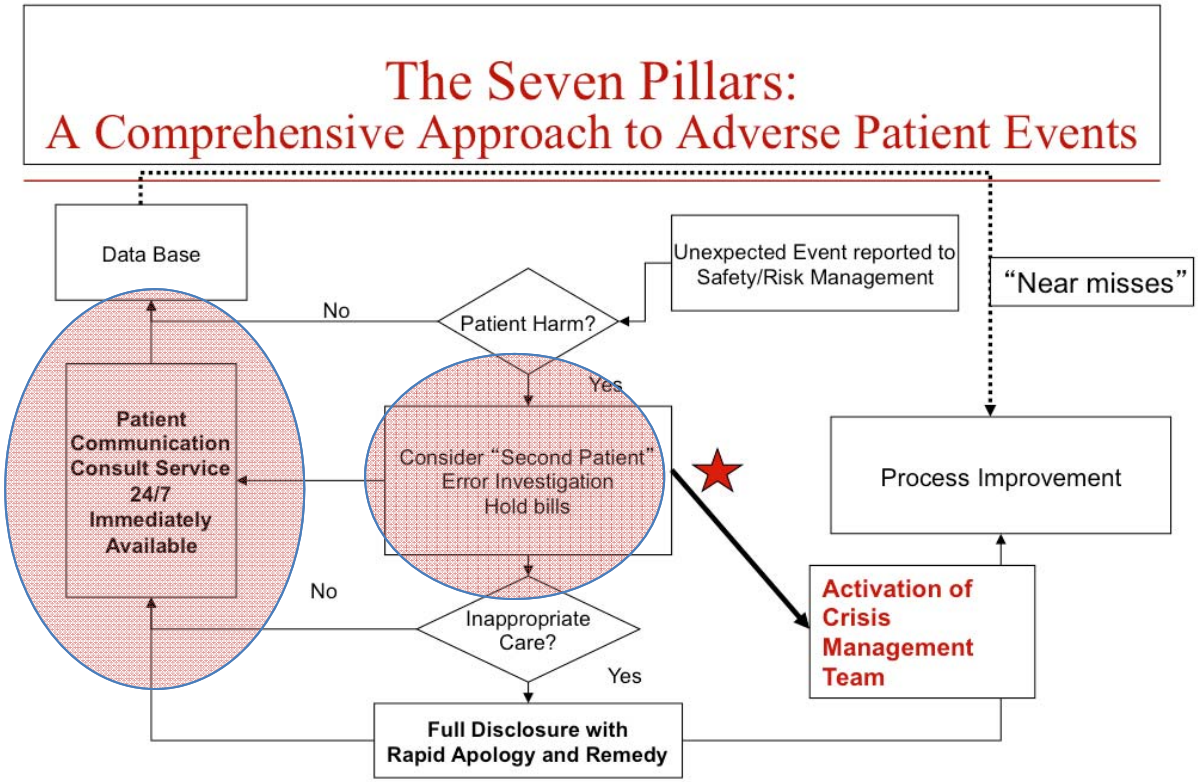
The Seven Pillars:
A Comprehensive Approach to Adverse Patient Events



When words and actions matter most – pillar 3 - communication



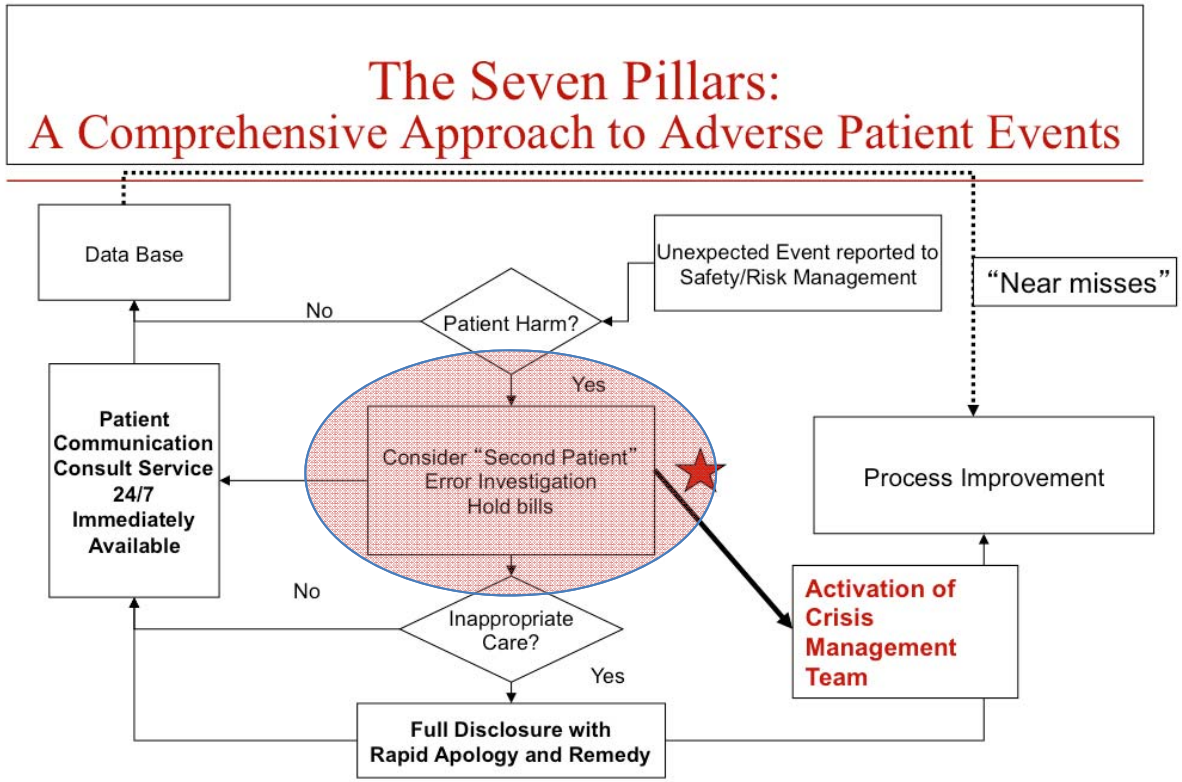
When words and actions matter most – step three – communication – with patients and families AND with clinicians involved in event



Empathic communication

Care for the caregiver

When words and actions matter most – step five - learning and improving



Need for CFC program

What I Learned About Adverse Events From Captain Sully

It's Not What You Think

MP Steigler, JAMA, 2015;313(4): 361-62.

"The well-being of physicians is directly tied to the well-being of their patients"

Care for the caregiver

- West CP, Hushchka MM, Novotny, PJ et al. Association of Perceived Medical Errors With Resident Distress and Empathy. A Prospective Longitudinal Study. JAMA. 2006; 296:1071-1078;

Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study

"Self-perceived medical errors are common among internal medicine residents and are associated with substantial personal distress. Personal distress and decreased empathy are associated with increased odds of future errors…reciprocal cycle."

Safety Attitudes

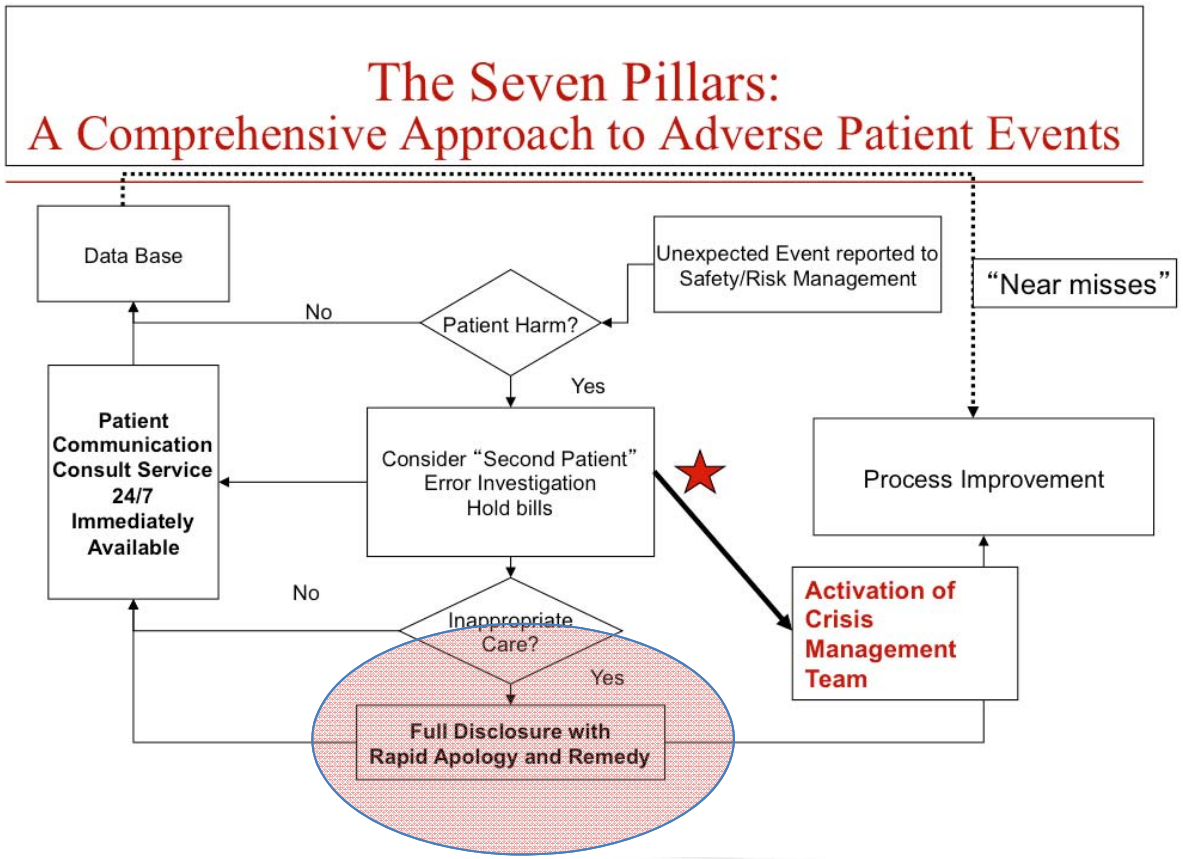
"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."

--Dr. Lucian Leape, Professor, Harvard School of Public Health
Testimony to congress

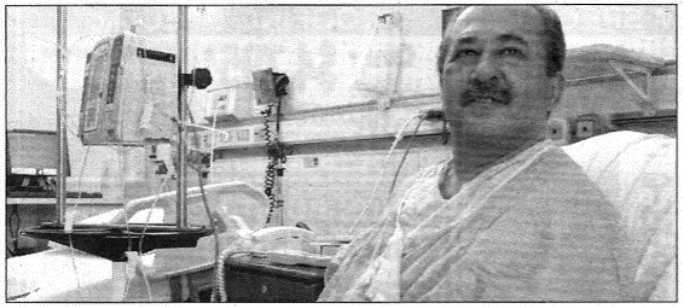
"Fallibility is part of the human condition. We *cannot* change the human condition. But we *can* change the conditions under which people work"

--James Reason, Ph.D.

When words and actions matter most – final step - resolution



Resolution beyond money



Marco Kuyachich recovers from transplant surgery Monday at Northwestern Memorial Hospital. He received the kidney after the death of a family friend.

MICHAEL MCARDLE ~POST-TRIBUNE

Death gives new life to friend

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

BY PIET LEVY
Post-Tribune

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

On Sunday, Ballog's kidney was given to Lake County (Ind.) Police Chief Marco Kuyachich, who has been awaiting a tranplant for two years. Ballog, 39, was the daughter of former Hobart Mayor Robert Malizzo.

"She was always there to help everyone," Malizzo said. "Even in her death, she wanted to help, and that's why she's a donor."

Michelle Ballog

Ballog, who had two daughters, died during liver surgery Saturday at the University of Illinois Medical Center.

Despite his grief, Malizzo remembered his friend Kuyachich needed a kidney. So, he called him.

"Sometimes there's a bright side out of a bad situation," Malizzo said. "My daughter gave [Kuyachich] the gift of life. What greater gift can you give anyone?"

Kuyachich said: "I'm hoping others will learn from this and follow her lead. You don't realize how much you can do for others until you have it done to you."

Comment at suntimes.com.

Process improvements following Michelle's case

- Immediate change in anesthesia coverage from complex sedation cases.
- Instituted use of capnography for all applicable sedation cases.
- Worked with the American Society of Anesthesiologists to establish capnography as a new standard for sedation cases.
- Worked with Accreditation organizations such as The Joint Commission to build capnography into the accreditation standards.

13 years of data

Proof of concept

HSR Health Services Research

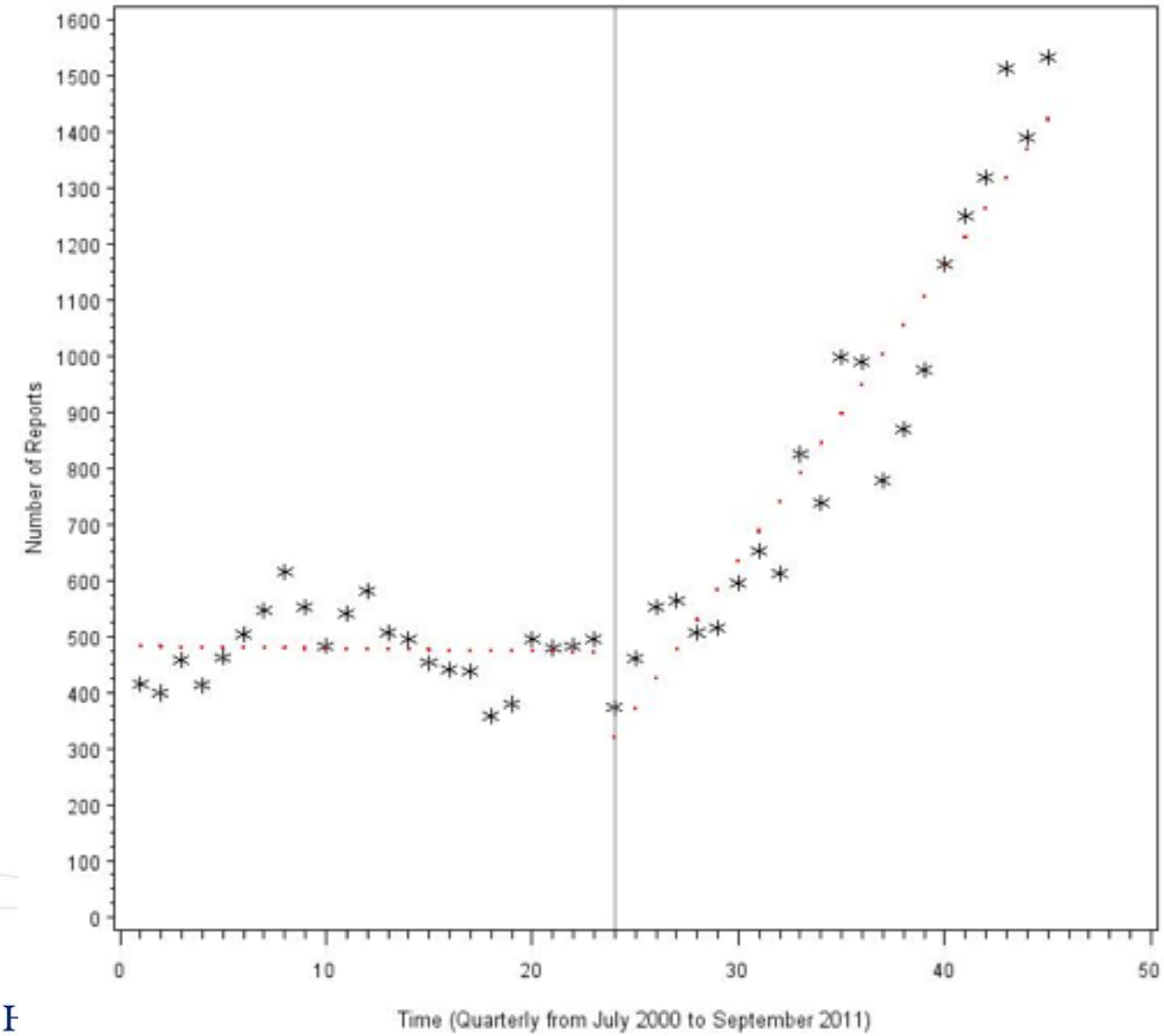
DOI: 10.1111/1475-6773.12548
SPECIAL ISSUE: PATIENT SAFETY & MEDICAL LIABILITY

The "Seven Pillars" Response to Patient Safety Incidents: Effects on Medical Liability Processes and Outcomes

Bruce L. Lambert, Nichola M. Centomani, Kelly M. Smith, Lorens A. Helmchen, Dulal K. Bhaumik, Yash J. Jalundhwala, and Timothy B. McDonald

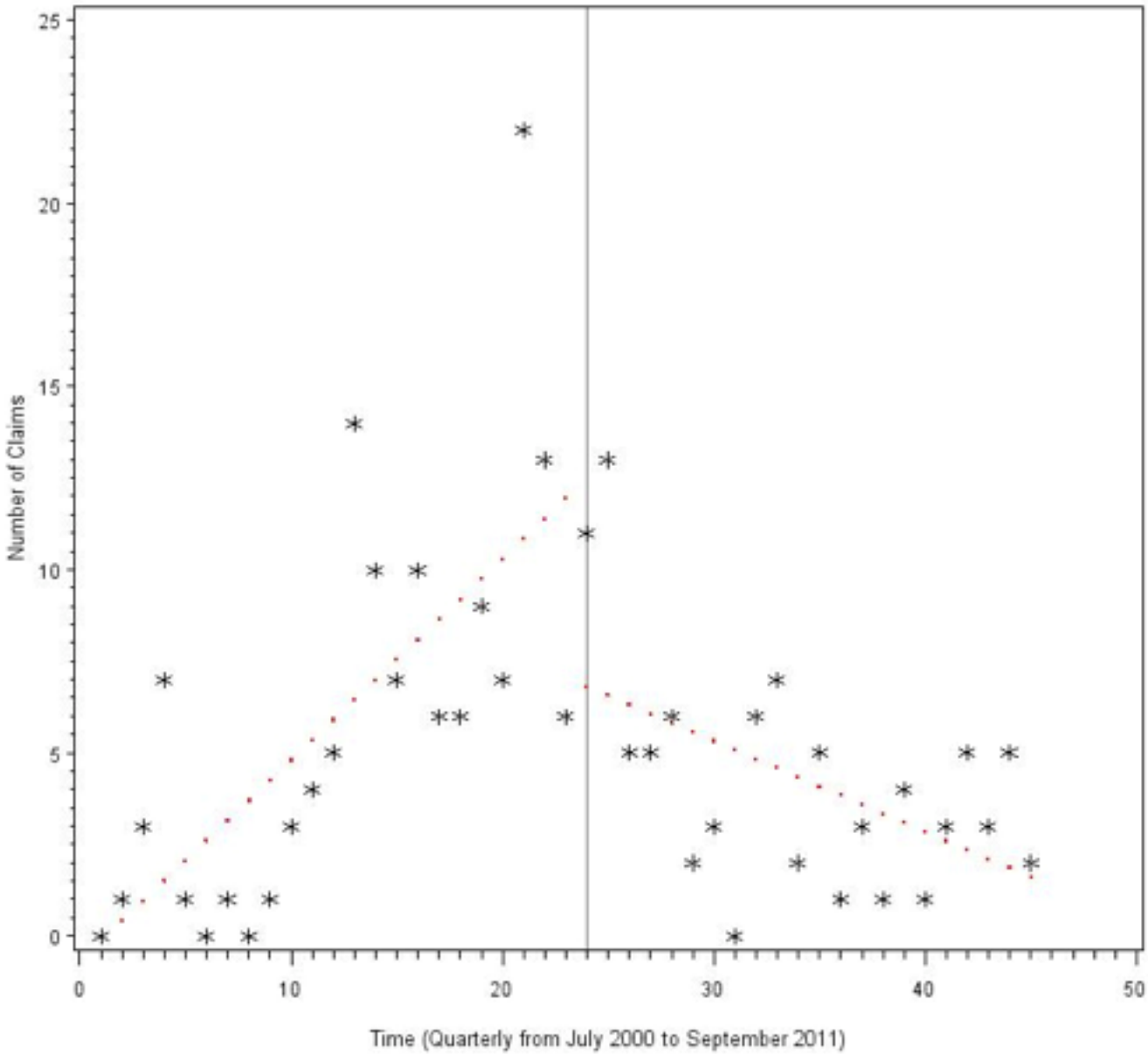
Effect of 7P on Adverse Event Reports

University of Illinois Hospital and Health Sciences System



Effect of 7P on Claims

University of Illinois Hospital and Health Sciences System



Premiums over time

Effects of Seven Pillars "Communication and Resolution" or "MEDiC" Program on Self Insurance Plan

Balance in self-insurance fund

Other critical data

- Statistically significant reduction in tests associated with defensive medicine
- Time to resolution reduced more than 60%
  - Care for caregiver impact is significant

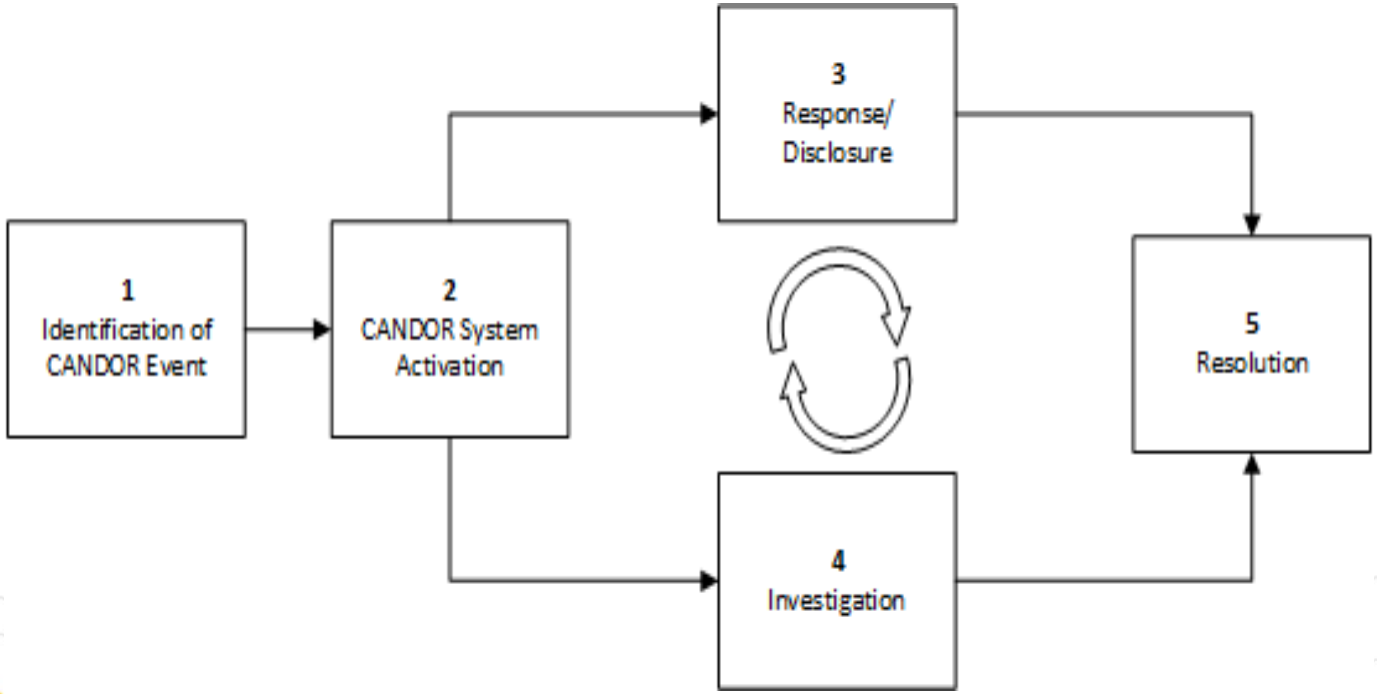
AHRQ Research Grants

AHRQ Research Grants

- Agency for Healthcare Research and Quality
- Task Order to create a CANDOR Toolkit
- Toolkit released, May, 2016
  - Organizational assessment tools
  - Event reporting
  - Event analysis – HF and process redesign
  - Communication training
  - Care for the Caregiver program implementation guide
  - Optimal Resolution tools
  - Patient and Family Partnership and Engagement

The Communication and Optimal Resolution: CANDOR Process

The CANDOR Process consists of five major "bundles" of activity that proceed in sequence and at times simultaneously.



Work with Kettering

- Communication workshop – Jan 18,19
- Event analysis, cognitive interviewing, PI – Feb
- Resolution – March
- Putting it all together - April

Questions