# The 9th Annual Communication, Apology, and Resolution Forum

## Part 1

Hosted by MACRMI in joint providership with
the Massachusetts Medical Society

With special thanks to the Coverys Community Healthcare Foundation

Virtual Forum – October 26, 2021

This session is being recorded for those who cannot attend live. We will take questions through typing box.

# Objective (Part 1)

- Recognize the possible biases we as healthcare workers may have, and understand ways to mitigate them

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# Disclosures


MASSACHUSETTS MEDICAL SOCIETY

*Every physician matters, each patient counts.*

9th Annual CARe Forum

October 26, 2021

**Disclosure Statement**

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# CME/Nursing Credit

After attending today's session you will receive a link to an evaluation (this can take up to 10 days). Once that is completed, you will receive a link to a CME certificate for download.

If you are a nurse, email the CME certificate to Melinda Van Niel (mvanniel@bidmc.harvard.edu) for nursing credits.

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# Massachusetts Alliance for Communication and Resolution following Medical Injury

# Today's Agenda

- Background:
  - What is CARe, and why do we use it?
  - Review of published data
  - Recent MACRMI Activities
- Keynote Presentation: Dr. Alice Coombs
  - "Think Again! Everyone doesn't think the same"
- Discussion session
  - with Dr. Coombs and MACRMI Co-Chairs

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# Communication, Apology, and Resolution (CARe)

- **What is it?**
- **Why do we use it?**
- **How do we know it works?**
- **How do you get started?**

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# What is Communication, Apology, and Resolution (CARe)?

- **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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# Why do we use it?

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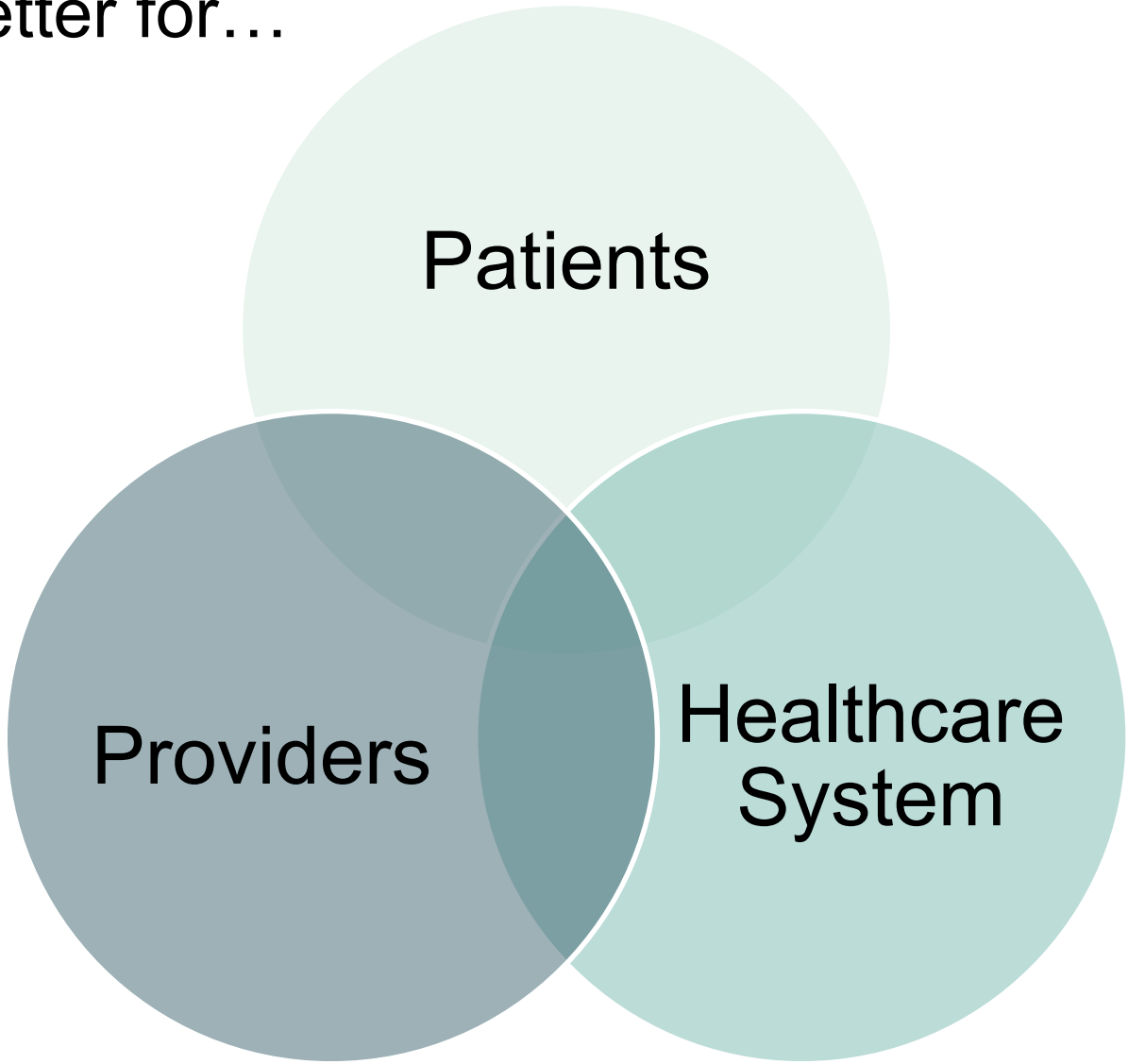
# It is better for…

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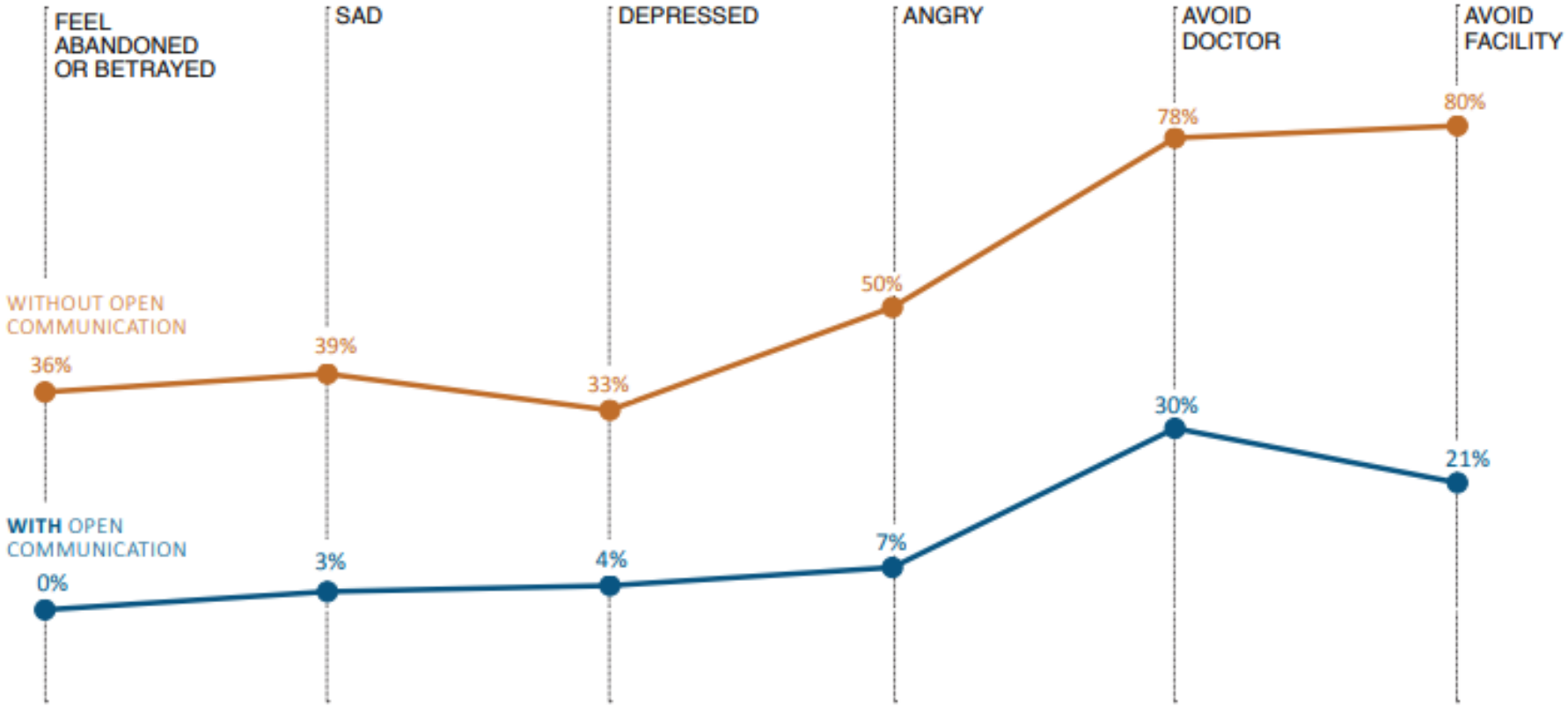
## OPEN COMMUNICATION FROM PROVIDERS IS LINKED TO LOWER LEVELS OF HARM




Data and graphic from the Betsy Lehman Center Cost of Medical Error Report – 2019-
https://betsylehmancenterma.gov/research/costofme

# How do we know it works?

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# Areas of Investigation - Massachusetts

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

# The Massachusetts Pilot Sites

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

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# Conclusions from MA Study

- **Claims did not increase** when program was used rigorously
- Large cost savings reported by some early adopters did not occur, but there were **no cost increases and some significant decreases**
- Hospitals can “do the right thing” without increasing their liability exposure
- Providers involved in cases supportive of CARe overall

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# Study-determinted 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 insurer
- Pre-existing just culture commitment
- **Sense of community and support from MACRMI**

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# How do you get started?

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# Join us!

1. Free implementation guidance by members who have built CARe programs from the ground up

2. Free tools and resources, and assistance using them

3. Community of experienced individuals from systems of different sizes, models, and locations to discuss challenges with

4. Wider community of members involved in all aspects of medical liability to learn from and work with

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# MACRMI Activities and Resources

Over the last year MACRMI has…

1. Helped 7 new facilities begin CARe implementation
2. Educated Medical Staff Services staff in the state about CARe and its impact on NPDB reporting
3. Continued to educate both those in MA and around the globe about the merits of CARe
4. Developed two new resources

*For Clinicians*

- Clinician FAQs Document

*For Safety/HCQ Staff*

- Talking to Involved Providers about CARe

# Website: www.macrmi.info

HORIZON INTERACTIVE AWARDS
BRONZE WINNER

MARCOM AWARDS


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# Think again! Everyone doesn't think the Same


Alice A Tolbert Coombs MD MPA FCCP

Chair and Professor

Department of Anesthesiology and Critical Care

Virginia Commonwealth University

Past- President of the Massachusetts Medical Society

# Disclosures

- VCU Health Anesthesiology Critical Care Medicine
- South Shore Hospital –Critical Care Medicine
- Consultant
- No Industry Funding
- There will be no discussion of off label medication use

# Objectives

- **1. Review the historical strategies to reduce health care disparities and improve outcomes**
- **2.Discuss the role of biases on decision making and health care outcomes**
- **3. Explain how patient health care literacy and empowerment can reduce and bad outcomes**
- **4. Discuss solutions which can decrease SSE**

# Background

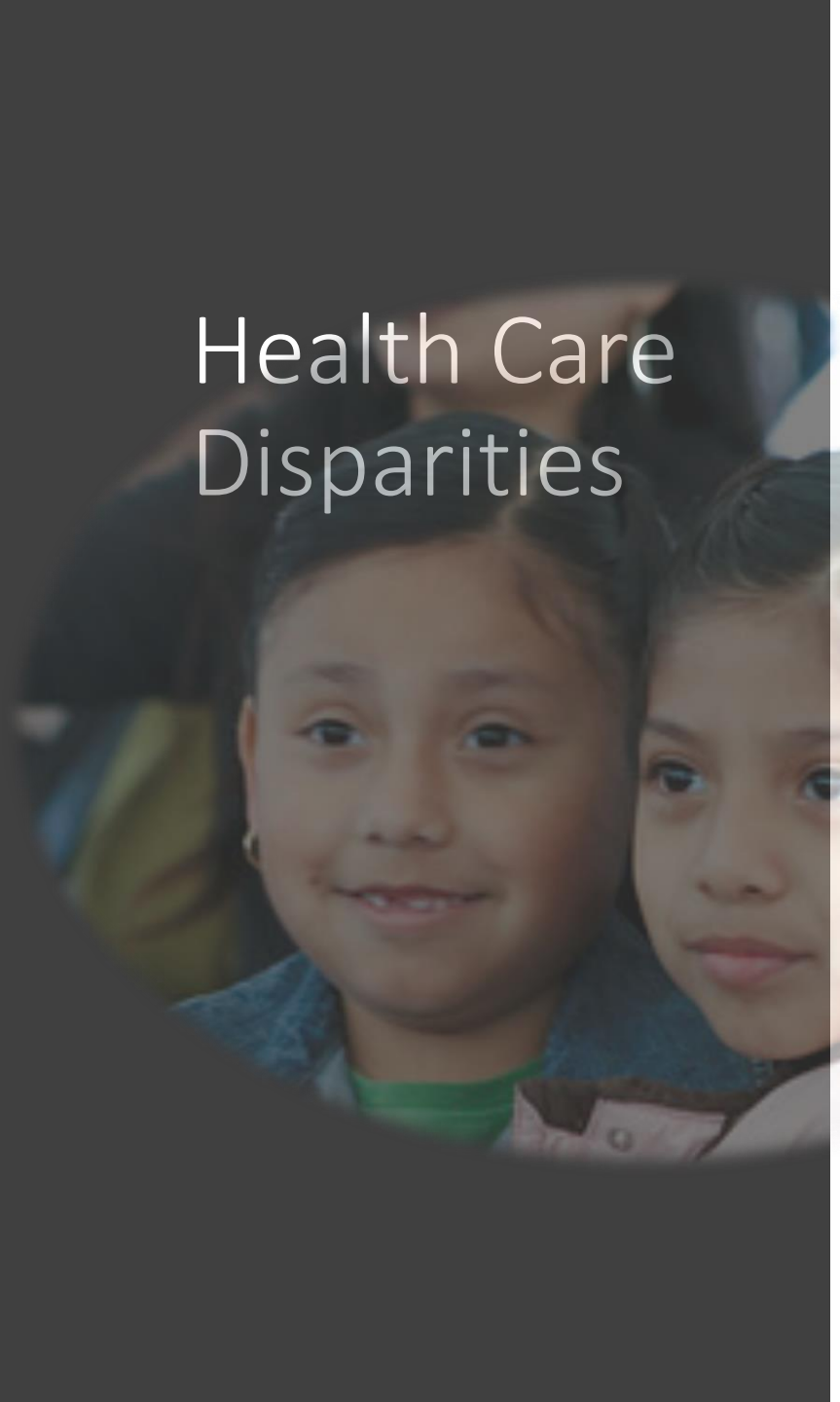
Compton to MGH

Family Background

Health and Health Care Disparities

Quality and Safety

# Health Care Disparities



CDC

- "**Health disparities** are preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal **health** experienc ed by socially disadvantaged racial, ethnic, and other population groups, and communities."

- **Health Care Disparities**- Differences in outcomes related to the delivery of health care or prevention or deficiencies in care

- 2002 "**IOM Unequal Treatment**" Disparities in outcomes exist in minorities regardless of Socioeconomic level or insurance coverage"

- Disparities exist in many other settings- Gender, Disability, Orientation

- Multiple etiologies require multi-prong approach

# Disparities in Quality and Safety Events
# Strategies to decrease Health Care Disparities

ACCESS- not always about the absence of engagement

Cultural Competency/Health Care Worker Awareness

Diversity of Workforce

Linguistic Concordance

Advocacy

Biases

# Woman Dies in ER Lobby as 911 Refuses to Help

## June 13, 2007

**Tapes show operators ignored pleas to send ambulance to L.A. hospital**

**Fury after woman dies in hospital lobby**

June 13, 2007

: NBC's Michael Okwu reports on a desperate 911 call made as a woman lay dying in a California hospital lobby.

**Associated Press** Updated: 10:43 a.m. ET June

“Edith Isabel Rodriguez, 43, died of a perforated bowel on May 9 at Martin Luther King Jr.-Harbor Hospital. Her death was ruled accidental by the Los Angeles County coroner’s office.
Relatives said Rodriguez was bleeding from the mouth and writhing in pain for 45 minutes while she was at a hospital waiting area. Experts have said she could have survived had she been treated early enough.”

# Disparities Quality and Safety

- How do we evaluate and does it matter ?

- ***Tale of last 90 minutes of woman's life* Remembering Edith Rodriguez**
- ***BY CHARLES ORNSTEIN***

# Value Proposition

Diversity

Diversity Workforce and Training yields Cultural Competency

- Combining divergent random groups

Joseph Stiglitz-Gaussian Curve

The Phenomena of the Nobel Laureate Dinner

# Impact of Workforce Diversity

- Increasing the supply of minority physicians increases access to medical care (Komaromy 96')
- AAMC 13, 428 MD Degrees between 1974-75
  - Results- "almost twice the proportion of minority graduates as non-minorities were practicing in federally designated manpower shortage areas (11.6 vs.6.1%, $p<0.001$)
- Black physicians practice in predominantly metropolitan areas (Rochleau 1978)
- Howard University School of Medicine alumni 55'-75'
  - 60% practice in large city , 32% in inner city

# Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care

- “Black respondents with black physicians were more likely than those with non-black physicians
  - Rated their physicians as **excellent**
    - (adjusted odds ratio [OR], 2.40; 95% confidence interval [CI], 1.55-3.72)
  - Report **receiving preventive care**
    - (adjusted OR, 1.74; 95% CI, 1.01-2.98) and all needed medical care (adjusted OR, 2.94; 95% CI, 1.10-7.87) during the previous year.
  - Hispanics with Hispanic physicians were more likely than those with non-Hispanic physicians **to be very satisfied** with their health care overall
    - (adjusted OR, 1.74; 95% CI, 1.01-2.99). Komaromy 99 Archives

## **Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools,** Saha S, MD, MPH; Guiton, G et.al.*JAMA.* 2008;300(10):1135-1145.

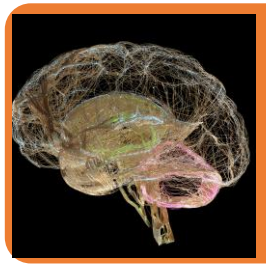
- Medical schools ask the question does Student Diversity matter?

1. The educational benefits of a more diverse schools resulted **in improve preparedness of students to address a more diverse patient populations** (survey responses) overall
2. **White students** within the Highest Quintile for Medical Schools Diversity were more likely to rate themselves as **highly prepared to care for minority populations** in the lower Diversity Quintile Schools
3. Also, the White students (diversified schools) were more likely to have a strong attitude to **endorse equitable access to care**.
4. URM minority medical students were more likely to **plan on serving underserved communities**

# Anatomy

- **Health Inequities/ Health Care Disparities**
- **Quality and Safety**
- **Decision-making** and **Biases**
- **Patient Empowerment**
- **Health Care Literacy**

# What do biases have to do with Serious Safety Events ?



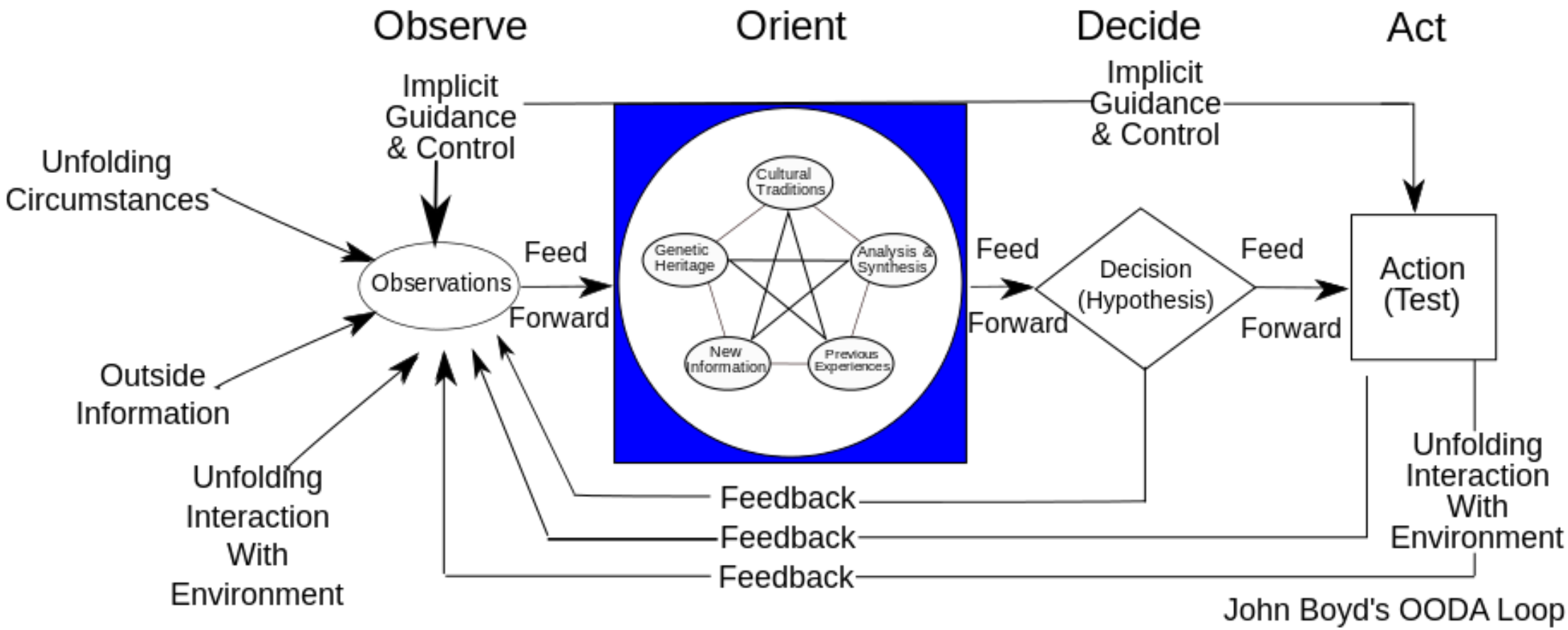
Jonathan Kahneman and Michael Tversky
Concepts that help to frame Decision-making

1. Affects your Perception and how you view people and situations

**2. OODA Loop – Observation, Orientation, Decision Action**

**OOADAR-Observation, Orientation, Decision, Response**

3. Impacts your response  or lack of response




John Boyd's OODA Loop

# Bias

Physicians should understand biases and racial and ethnic discrimination historical roots, and implications for health disparities

Existing methods to discuss racial inequality in physician training

- **Health disparities**: awareness over critical examination of disparity origin from social, historic, and economic reasons
- **Cultural Competency:** often mobilize stereotypes of  People of color  in efforts to cite behavioral choices as likely causes of health disparities
- **Implicit bias:** encourage increased recognition of personal prejudices but fail to consider structural inequities

# Thinking Fast and Slow Health Care Disparities

- Distinguishing between unconscious bias and decision making
- Cultural
- Familiarity
- Learned behavior
- Heightened Vigilance

- Choice Architect- Designing systems to combat HCD
- Incentives
- Developing a self-preference veer right Negative or Positive reinforcement
- Habits

# Patient Safety Gaps
# HCW Decision Making influences by Biases

Examples

Chest Pain –ED evaluation of women

Hispanic male with pain from long bone fractures

Number of AA receiving heart transplants

The number of males receiving leg amputation (limb salvage vascular bypass )

- Implicit Bias
- Recency bias
- Confirmation Bias
- Availability Bias
- System 1 vs System 2 thinking
- Altered SUNK COST Bias
- Nudges

# Biases and the Patient- Physician Relationship

- Room full of people
- Eye Contact
- Proximity Factor
- Untouchable
- **Affinity Quotient**

# SSE Drill down

- **Systematic analysis of cases and contributing factors, adapted from (e6)**

| Contributing factor | Explanation |
|---|---|
| Patient factors | Illness; social, physical, or psychological conditions; relationship between patient and outpatient practice/hospital; language; articulateness; personality |
| Task factors | How the process is structured; are protocols/standards available? |
| Individual (staff) factors | Knowledge, skills, education/training, stress levels, health, motivation |
| Team factors | Verbal and written communication, team structure, supervision, seeking help |
| Work/environment factors | Staffing levels, staff qualifications, work stress, design, availability and servicing of equipment and devices, environmental conditions, noise, distractions |
| Organizational and management factors | Resources, restrictions, structure of practice (single-handed or group practice) or structure of hospital, existence of and handling of rules, regulations, safety culture, and priorities |
| Institutional context | Financial situation/funding of the organization, requirements imposed by the liability insurers, legal/statutory requirements (quality management) |
| Safety barriers/defenses | Existing, reliable, and known? Might the safety barriers have prevented the event? |

# The Nature of Serious Safety Events and Decision making Solutions

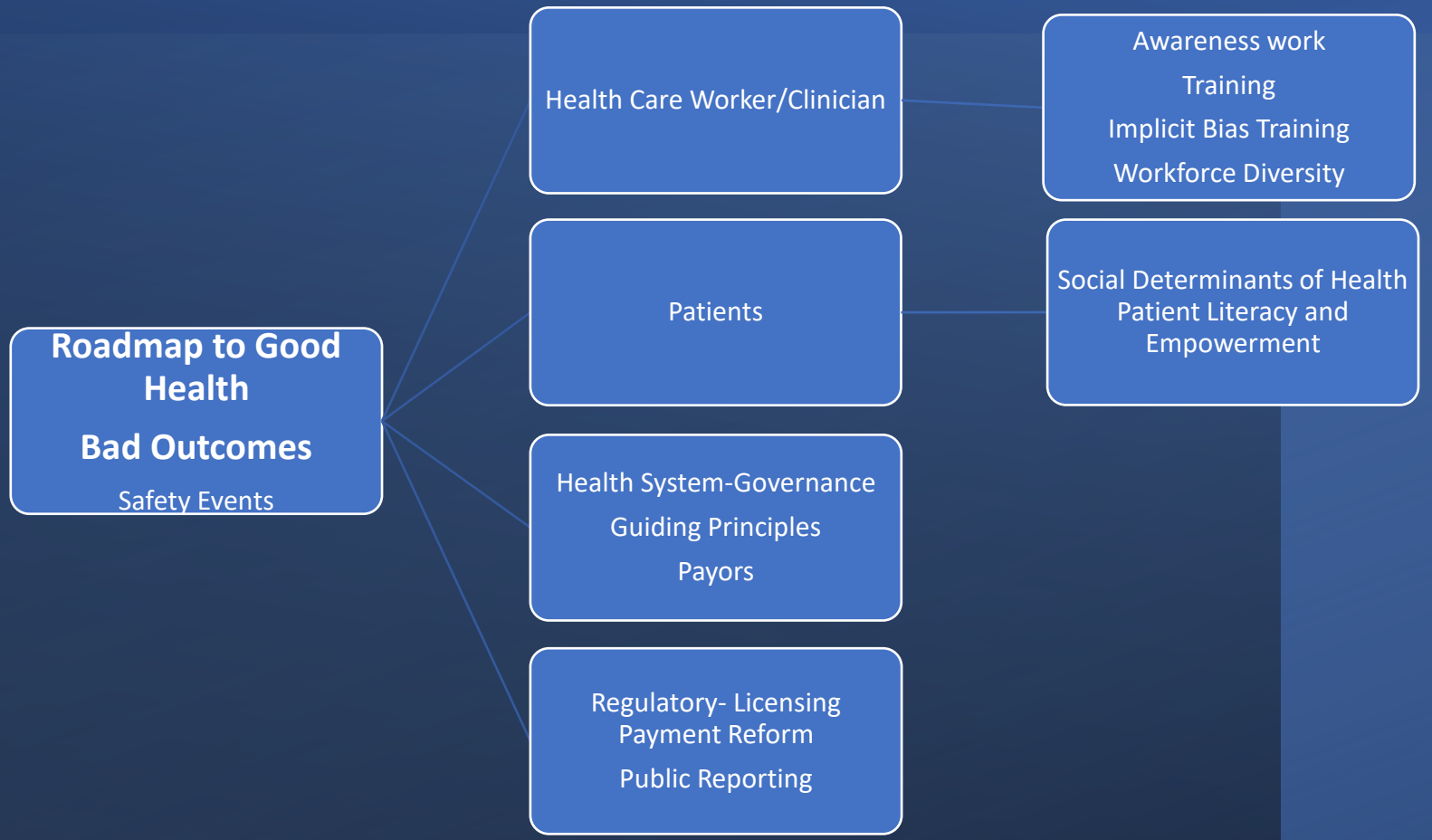
- Anatomy of Serious safety events (SSE)
- Creations of Algorithms in response to SSE
- Safe Patterns of Care
- Check and Balances
- Habit forming exercises
- Culture of transparency and call out
- Stop the line

## Are we able to go to zero SSE?

# Transparency

- Medical Trainees challenges
- Escalation of Care
- Attending Accountability
- Marry two ideals for success

# Moving ON to Solutions



# Health Care Literacy Empowerment

# For Want of a Dentist

Washington Post, Wednesday, February 28, 2007; Page B01

- Deamonte Driver, sitting next to his mother, Alyce,.
- Twelve-year-old Deamonte Driver died of a toothache Sunday.

# Health Disparities and Health Care Economics

- Inequality in Economics Mirrors Inequality in Health Care Disparities
- Top 1% Americans control some 40% of the Nation Wealth
- Disparity in wealth growth the evolution of Self interest over community interest
- Higher unemployment, wage gradient,
- Market Distortions-invisible hand, supply demand curve
- Wealth dominated Political Agendas

- Resource limitations yields default decision making (9million person uninsured make 75k or more)
- Regulation-ACA
- Mal-distribution of workforce/resources
- Right persons on the Bus
- Disincentives
- Discretionary

# Health and Health Care Literacy

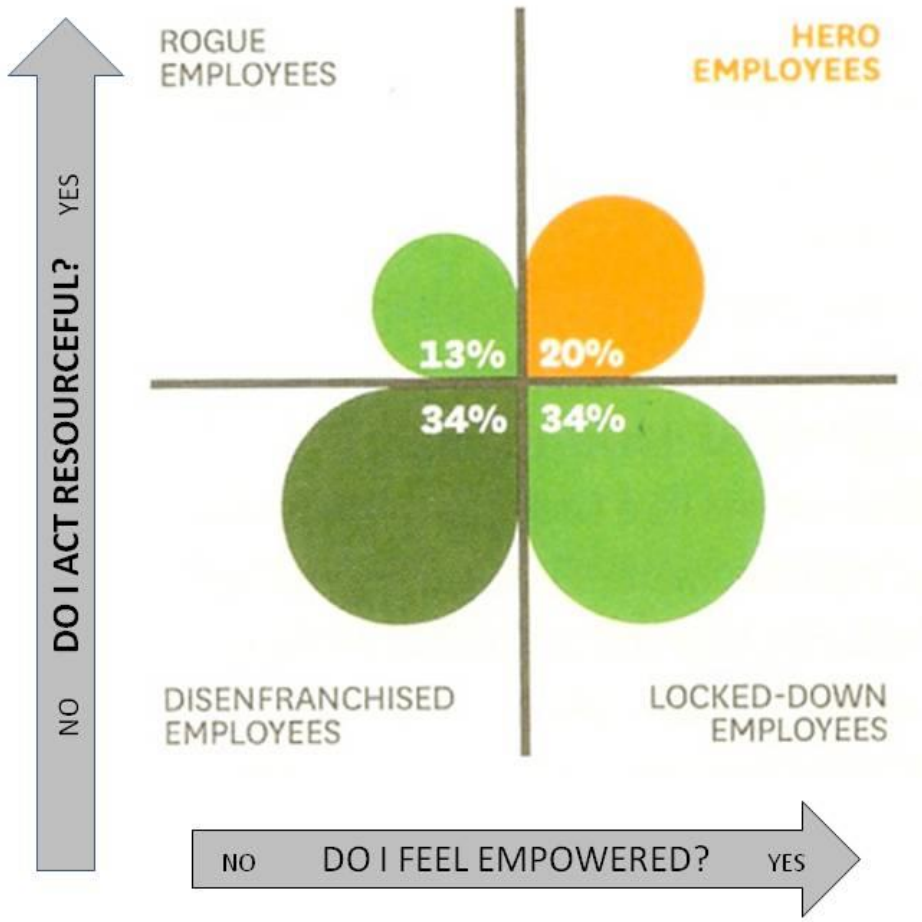
- Definition
- Fundamental Knowledge
- Resourcefulness- Do you use resources and how do they benefit you?
  - Information
  - Experiences
  - New disruptive ideals-Taking info and utilizing it
    - Patient sawed off part of four finger tips on His Left Hand and goes to the local clinic
- Empowerment- Am I motivated , confident to solve problems engage in changing my circumstances to improve status or Outcome

# Social Context Barriers to Health Care

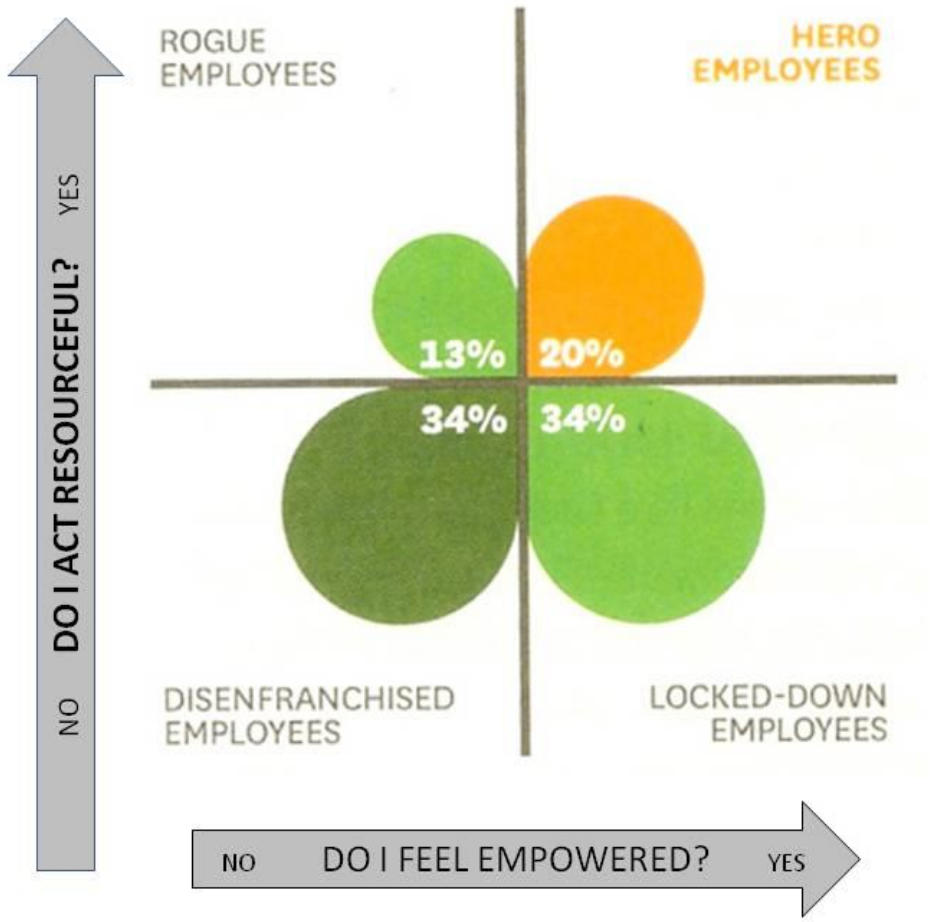
- Poverty
- Lack of insurance
- Physical Barriers
- Limited access to health care
- Education

- Language
- Cultural competence
- Poor provider attitudes: stereotyping, prejudice, bias

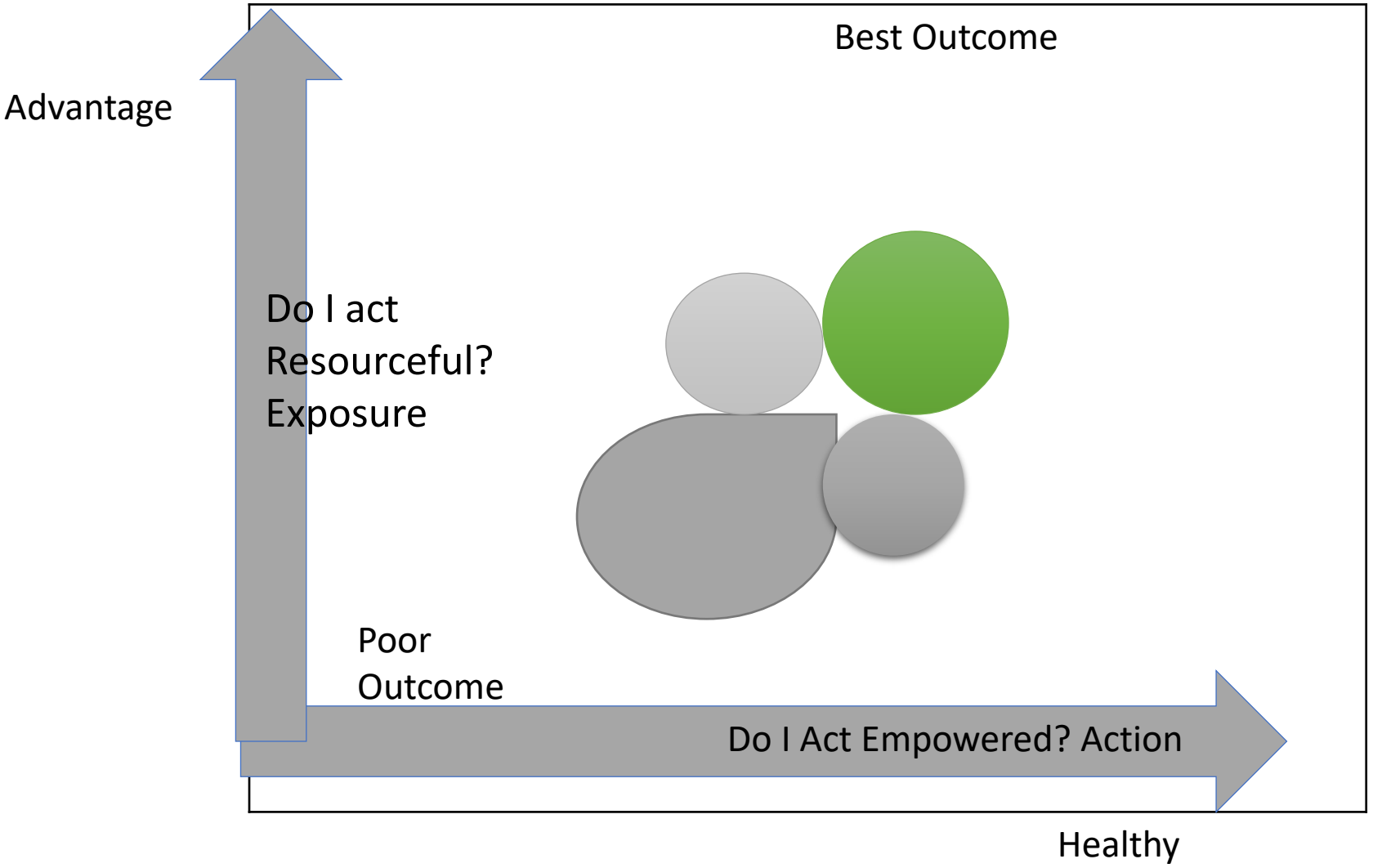
Harvard Business Review-*Empowered* J Bernoff ,T Schadler July-Aug 10’ Survey of 5000 Workers



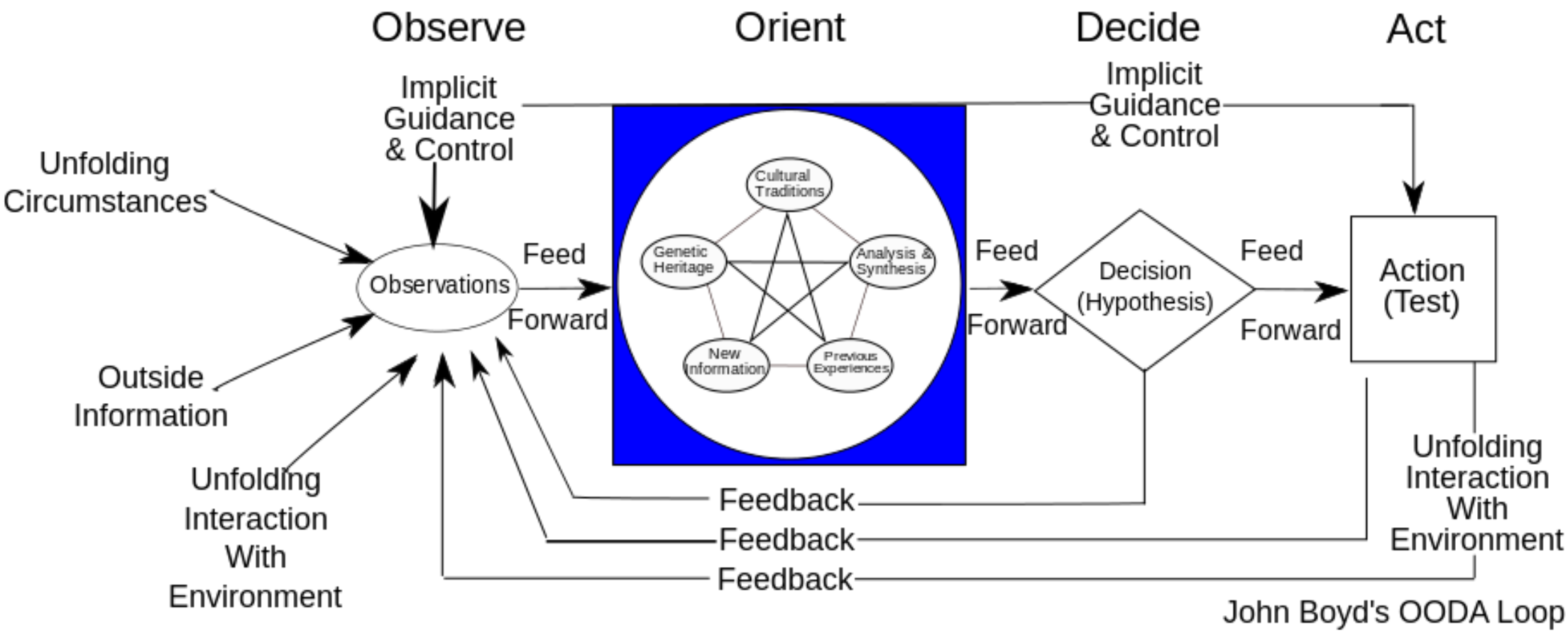
# Patients


ROGUE EMPLOYEES
HERO EMPLOYEES
13%
20%
34%
34%
DISENFRANCHISED EMPLOYEES
LOCKED-DOWN EMPLOYEES
NO
DO I ACT RESOURCEFUL?
YES
NO
DO I FEEL EMPOWERED?
YES

# Patients


Best Outcome
Advantage
Do I act
Resourceful?
Exposure
Poor
Outcome
Do I Act Empowered? Action
Healthy

# OODA


Observe
Orient
Decide
Act
Implicit Guidance & Control
Implicit Guidance & Control
Unfolding Circumstances
Observations
Feed Forward
Cultural Traditions
Genetic Heritage
Analysis & Synthesis
New Information
Previous Experiences
Feed Forward
Decision (Hypothesis)
Feed Forward
Action (Test)
Outside Information
Unfolding Interaction With Environment
Feedback
Feedback
Feedback
Unfolding Interaction With Environment
John Boyd's OODA Loop

# Case Presentation

- 27 Y/o AA M with HTN on Lisinopril went to ED at 0630 in am to a hospital complaining “swollen tongue and difficulty speaking”.
- MD, Dx angioedema secondary to lisinopril, admitted to the ICU for close monitoring .
- Next 8 hrs. waxing waning course, drooling, eat popsicle
- 3-5pm increased tongue swelling, muffled speech,
- 7-8pm had difficulty breathing
- BIPAP applied, increased agitation midazolam administered, Decreased O2 saturation,
- Surgical resident and second year medical resident care for Maurice
- ,Anesthesiologist was called , couldn’t intubate, resident attempt unsuccessful  Crico-thyroidotomy, patient had cardiac arrest ROSC to OR
- ENT called in (at home) to do emergency trach, arrive in OR after he is resuscitated
- Trach performed
- Patient has irreversible Severe Anoxic Brain damage- Passed away

# Mother Response Lisa Parks

Thanks so much Lisa Parks for agreeing to participate in this part of the Program

Describe to us what you were feeling at the Family in which your son prognosis was discussed

# Questions

# Quality  Safety

- Falls
- Catheter related -Infections
- C Difficile Colitis
- Line infections
- Prolonged Mechanical Ventilation
- Aspiration Pneumonia

- Wrong Site Procedures
- Ventilator Disconnection
- Hyperkalemia Untreated
- Retained Foreign Body
- Unsupervised Trainee
- Impaired HCW
- Lack of equipment or resources