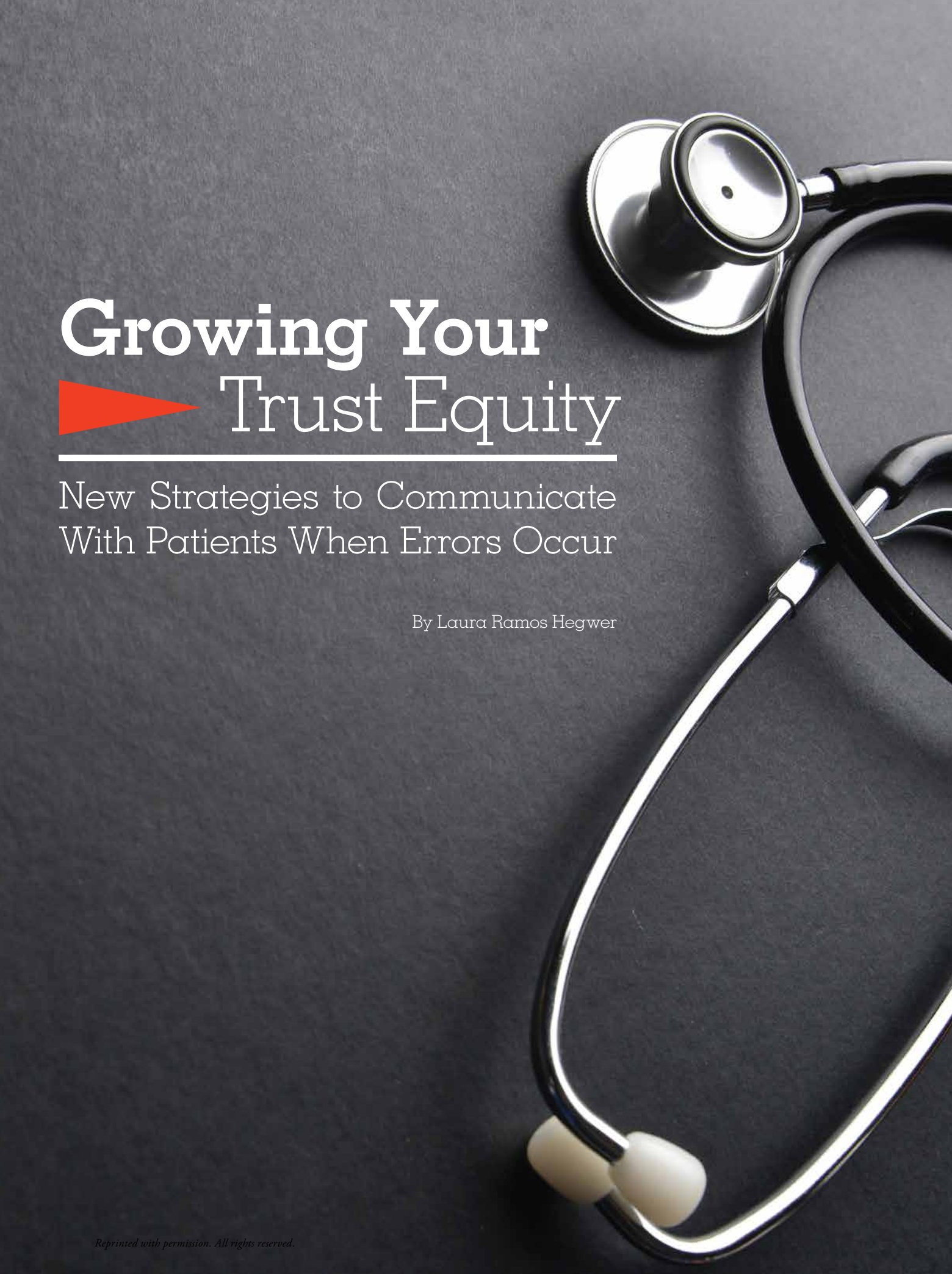

Growing Your Trust Equity

New Strategies to Communicate With Patients When Errors Occur

By Laura Ramos Hegwer

Though most hospitals have adopted policies that promote treating patients with respect and honesty when medical errors occur, these policies are not always uniformly applied, says William A. Nelson, PhD, HFACHE, associate professor, Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine, Dartmouth College, Lebanon, N.H. As a result, trust breaks down between patients and providers.

Building equity in a "trust bank" with patients is important not only from an ethical standpoint but also because adopting a more transparent culture can help hospitals realize numerous benefits. "Building trust certainly can enhance the patient experience," Nelson says. It also can provide a competitive edge to organizations that face significant market competition. "Patients are looking for healthcare providers they can truly trust to act in their best interest," he adds.

Nelson, who serves as adviser to the ACHE Ethics Committee, believes C-suite leaders play a key role in setting expectations that are essential to creating a culture of transparency in their organizations.

"CEOs spell out how the relationship is going to be between the patient and the physician," Nelson says. They also can provide the mechanisms and oversight necessary for building trust across the enterprise.

Provider Responses That Build Trust

Studies suggest there is a right way to respond to medical errors and help ensure your organization is steadily growing its trust equity with patients.

Growing Your Trust Equity

Case Study: University of Washington Medical Center, Seattle

"New practices and strategies are emerging that can help healthcare providers respond to adverse events in a way that not only meets patients' needs but also promotes disseminated learning," says Thomas Gallagher, MD, general internist and professor, Department of Medicine and Department of Bioethics and Humanities. He also directs the UW Medicine Center for Scholarship in Patient Care Quality and Safety.

"Organizations that consider how they respond to adverse events as a component of their quality and safety program have much more success than organizations that view this as a risk management strategy," says Gallagher, who has published widely on patient-provider communication after medical errors.

His research has found that when an error occurs, "patients care a lot about the conversation," he says. Specifically, patients want an apology and assurances that the provider will implement a plan to prevent future errors. These findings helped spur the creation of communication and resolution programs at hospitals around the country. "CRPs are comprehensive, principled and systematic approaches that organizations use to respond to an adverse event," Gallagher says. "They start with making sure that a strong, just culture is in place and that healthcare workers are encouraged to report adverse events right away."

CRPs include several essential elements as outlined by the Collaborative for Accountability and Improvement, which Gallagher directs. One component is following each error with a rigorous analysis that focuses on the human factors and system failures leading to the event, he says. Another is providing support for caregivers. This element is important because Gallagher's research has shown that providers often experience enormous distress following an error, which increases the likelihood of a future error.

Another key aspect of a CRP is proactively offering fair financial or nonfinancial resolution to the patient for adverse events caused by unreasonable care.

The University of Washington has long adhered to the core principles of a CRP, including a tradition of early and robust event reporting; a commitment to the disclosure of medical errors and unanticipated outcomes of care; careful analysis of adverse events using intensive review and root cause analysis; provider support; and working with patients and families to resolve their concerns about care, including financial compensation, when appropriate.

When done well, the impact of CRP programs can be dramatic, Gallagher says. Organizations may see improvements in their quality and safety metrics, face fewer lawsuits or settle cases for less money, he adds.

Yet some organizations make the mistake of only leveraging their CRPs for some, and not all, cases, Gallagher says. "When you only implement these programs selectively, you fail to achieve the benefits on the culture of quality, safety and transparency that are required for these programs to work well," he says.

Gallagher also has studied how organizations handle disclosures of large-scale adverse events that affect more than one patient. One study published in *The Journal of Clinical Ethics* focused on an event that occurred in 2004 involving 266 patients at the University of Washington Medical Center. The patients received a letter informing them about a low-risk event caused by an incomplete endoscope cleaning process. Gallagher and his colleagues surveyed patients after mailing the notification letter and found 98 percent thought UWMC was right to inform them about the event. Sixty percent of those surveyed said their impressions of the medical center's honesty and integrity increased after the notification.

Growing Your Trust Equity

"These findings show the importance of disclosing these events to patients, even if the risk of harm to the patients is very low," Gallagher says. Disclosing large-scale events that involve higher levels of risk should include a personal conversation with the patient, typically led by the caregiver. Hotlines also can help to answer patients' questions quickly during these situations, he says.

Normalizing Honesty to Build Trust

Some organizations find that improving disclosure can reduce litigation costs while building trust.

Case Study: University of Michigan Health System, Ann Arbor

In 2001, the health system implemented what is now known as the Michigan Model, its approach to managing medical errors and malpractice claims.

"There's a common misconception that this model is primarily used to reduce money spent on medical malpractice costs," says Richard C. Boothman, JD, chief risk officer. Although the model has reduced the number of malpractice cases, its real purpose is to promote a culture of quality and safety improvement and to "normalize honesty," he says.

"The industry has believed for most of my career that the minute you are honest with a patient, you have a financial catastrophe on your hands," says Boothman, a former trial lawyer. "But what we have found is just the opposite."

According to Boothman, the Michigan Model's claims management process is based on three tenets. First, if a patient is hurt because of unreasonable medical care, UMHS is committed to moving quickly, honestly and fairly to compensate the patient for the injuries caused.

Second, if the care was reasonable but still resulted in injury, UMHS owes its staff members strong support. This means the organization still provides patients a full explanation, but it does not engage in so-called nuisance settlements, which can create a toxic environment for caregivers who feel the organization will not back them against false allegations, Boothman says.

Third, UMHS aims to learn from an honest evaluation of unanticipated clinical outcomes and drive the learnings into meaningful quality and safety improvement. "As part of our own evaluation, we ask our clinical leaders what they've done so the injury or failure doesn't happen again," he says. "Closing that loop further stimulates a culture of improvement."

To support these tenets, leaders at UMHS have robustly leveraged their incident reporting system—robustly being the key factor. In 2015 alone, the system received 34,000 incident reports. But because the voluntary reporting system relies on the individuals involved to make reports, it can still miss adverse events. As a result, UMHS uses a variety of strategies in addition to encouraging use of its electronic reporting system to identify unanticipated clinical outcomes. Boothman says it is critical for UMHS to distinguish between undesirable outcomes in spite of good care and those that occurred as a result of avoidable mistakes. Consequently, the health system created a medical liability review committee, which includes a total of 32 caregivers representing most disciplines who meet monthly to review the cases and vote on whether the care provided was reasonable. Cases considered have been reviewed internally and often are subjected to external expert reviews as well.

Leaders at UMHS also have embraced more open communication with patients rather than relying on a "deny and defend" strategy that many healthcare organizations still employ, Boothman says. "These organizations let the potential defense of litigation, even in the acute phase, drive their unwillingness to stay in the saddle with their patient," he says. "This has created bitter feelings of abandonment and mistrust between the patient and the caregiver."

As soon as it is alerted to a problem, Boothman's team dispatches a risk manager, a supervisor or the involved

clinician to the bedside, depending on the situation. Staff first attend to the patient's and family's immediate needs in the acute stage. As for the potential of a claim, they begin by listening to the patient to determine what questions the patient may have and who on the care team the patient might want to hear from down the road. This step allows the team to tailor the communication and resolution approach to each patient. At UMHS, most risk managers are trained in formal mediation techniques to help guide conversations and negotiations that occur with patients.

Boothman credits greater openness with patients for helping reduce the number of claims against the health system. Back in 2001, the system had roughly 300 claims on the books, most in some form of litigation, he says. For 2016, at press time, UMHS had approximately 80 cases in review and fewer than 10 in active litigation, despite doubling its clinical volume during the past 15 years. This approach also helped UMHS reduce its legal costs by approximately 60 percent between 1995 and 2007, as reported in the *Annals of Internal Medicine.* During that time, UMHS also invested in its internal infrastructure to meet quality and safety imperatives.

Boothman says the work the organization has done to improve communications with patients after an event also helped create better communication with patients regarding informed consent before care. "Being honest with

Defining Reasonable Care

"American law does not hold anyone to a standard of perfection—instead, it's a standard of 'reasonableness under the circumstances,'" says Richard C. Boothman, JD, chief risk officer, University of Michigan Health System, Ann Arbor. Jury instructions, for instance, alert juries that caregivers are obligated to perform as a "reasonably prudent physician of the same training and experience the defendant has under the circumstances."

UMHS' medical liability review committee meets monthly to review cases and vote on whether the care provided was reasonable. "We've elected to just ask our committee to determine what they felt was reasonable once they understand the circumstances," Boothman says. "We don't want this to be legalistic. Instead, we want them to be accountable."

The committee asks simple questions to determine what is reasonable care:

- Is this the care you want to model for our residents?
- Is this the care you would want for your own family?
- If one of your faculty members did the same thing, would you applaud it or criticize it?

"You don't need a courtroom to know when the care is up to your standards," Boothman says.

patients after bad things happen has highlighted the importance of preparing patients for the choices they make before anything bad happens," he says.

Lessons Learned

Building trust with patients requires continued efforts by front-line staff, middle managers and the C-suite. Executives should consider the following advice from experts on using communication strategies to improve the patient-provider relationship.

Explore tools that support open conversations and shared decision making. Nelson of Dartmouth recommends resources such as those from Choosing Wisely, an initiative of the American Board of Internal Medicine Foundation. These tools can help providers and patients have evidence-based discussions about appropriate care. Patients are more likely to feel like their caregivers are acting in their best interest if providers discuss the evidence supporting various treatments with them, Nelson says.

Encourage patients to speak up. Gallagher of UW is currently involved in a pilot program with MedStar Health, Columbia, Md., called "We Want to Know." Funded by the Agency for Healthcare Research and Quality, the program encourages patients to voice their concerns to help caregivers address care breakdowns or potential medical errors without fear that their care would get worse.

Invest in communication coaching for staff. "If employees are involved in an adverse event, they can call a communication coach right away and get help preparing for the initial conversation with the patient," Gallagher says. These peer coaches include in-house staff such as department heads, service line directors, social workers, surgeons, risk managers and other clinicians. "Even clinicians who have had training in these conversations find that just-in-time practice and rehearsal with a coach can help them be ready to talk to a patient," he says.

Engage independent physicians from the medical staff and their liability insurers in the planning discussions for CRPs. "If hospitals want to move in this direction [toward open communications with patients in the aftermath of medical error events], but the physicians' insurers do not, then the process breaks down," Gallagher says.

Record patients on video who are willing to share their stories. Leaders at UMHS use these videos as teaching tools with residents and attending physicians. They also invite affected patients to speak about their sentinel event experiences during grand rounds.

Develop a sense of ownership. "Healthcare leaders need to have a sense of ownership over how their health system responds to people who have unintended clinical outcomes," Boothman says. "The days of deferring to an insurance company and believing you have discharged your obligation to your patient and your organization are gone."

Similarly, leaders can encourage staff to take greater ownership of the care they provide to patients. Boothman, who also is on the board of directors of the Collaborative for Accountability and Improvement, says the fundamental goal of the Michigan Model is to create accountability among caregivers for outcomes, not lessen the cost of malpractice settlements. UMHS has compensated more than a dozen patients in the past 15 years for unreasonable care even though the statute of limitations had expired in their situations.

Forget the traditional wisdom surrounding medical mistakes that honesty isn't the best policy. As Boothman says, "People are far more forgiving than you think, so don't be afraid to be honest."

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