When words and actions matter most: The Case for CANDOR

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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
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”
Overview of Patient Safety

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

“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
Overview of Patient Safety and Anesthesiology

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

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Knowledge and Compassion Focused on You
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
Until 2003 we had a sturdy wall of silence

- COO of sister hospital
- Came to the University for plastic surgery
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- She dies 6 weeks after surgery from leukemia
- We said nothing to fiance or other family members
Until 2003 we had a sturdy wall of silence

• COO of sister hospital
• Came to the University for plastic surgery
• Abnormal WBC count – missed
• She dies 6 weeks after surgery from leukemia
• We said nothing to fiance or other family members
• We litigated for years, paid millions, learned little
What about Candor, Professionalism and Safe Culture?

- Barriers
- Benefits
What about CANDOR

- **Benefits**
  - Maintain trust
  - Learn from mistakes
  - Improve patient safety
  - Employee morale
  - Psychological well-being
  - Accountability
  - Money
  - Less legal involvement

- **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
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
<table>
<thead>
<tr>
<th>Paradigm Shift</th>
<th>Traditional Response</th>
<th>Communication and Optimal Resolution (CANDOR) Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident reporting by clinicians</td>
<td>Delayed, often absent</td>
<td>Immediate</td>
</tr>
<tr>
<td>Communication with patient, family</td>
<td>Deny/defend</td>
<td>Transparent, ongoing</td>
</tr>
<tr>
<td>Event analysis</td>
<td>Physician, nurse are root cause</td>
<td>Focus on Just Culture, system, human factors</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>Provider training</td>
<td>Drive value through system solutions, disseminated learning</td>
</tr>
<tr>
<td>Financial resolution</td>
<td>Only if family prevails on a malpractice claim</td>
<td>Proactively address patient/family needs</td>
</tr>
<tr>
<td>Care for the caregivers</td>
<td>None</td>
<td>Offered immediately</td>
</tr>
<tr>
<td>Patient, family involvement</td>
<td>Little to none</td>
<td>Extensive and ongoing</td>
</tr>
</tbody>
</table>
The Seven Pillars: A Comprehensive Approach to Adverse Patient Events

Data Base

Patient Harm?

Yes

Consider “Second Patient” Error Investigation
Hold bills

No

Inappropriate Care?

Yes

Full Disclosure with Rapid Apology and Remedy

No

Patient Communication Consult Service 24/7 Immediately Available

Unexpected Event reported to Safety/Risk Management

“Near misses”

Process Improvement

Activation of Crisis Management Team

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Knowledge and Compassion Focused on You
When words and actions matter most – pillar 3 - communication

The Seven Pillars: A Comprehensive Approach to Adverse Patient Events

- Data Base
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    - Yes
    - Consider “Second Patient” Error Investigation Hold bills
      - No
      - Inappropriate Care?
        - No
        - Yes
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      - Yes
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        - “Near misses”
        - Process Improvement
        - Activation of Crisis Management Team

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Knowledge and Compassion Focused on You
When words and actions matter most – step three – communication – with patients and families AND with clinicians involved in event

The Seven Pillars: A Comprehensive Approach to Adverse Patient Events

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January 20, 2017
Empathic communication
Care for the caregiver
When words and actions matter most – step five - learning and improving

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24/7 Immediately Available

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Need for CFC program


“The well-being of physicians is directly tied to the well-being of their patients”
Care for the caregiver

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

The Seven Pillars: A Comprehensive Approach to Adverse Patient Events

- Data Base
  - No
  - Yes: Patient Harm?

- Patient Communication Consult Service 24/7 Immediately Available
  - No
  - Yes: Consider “Second Patient” Error Investigation Hold bills
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  - Activation of Crisis Management Team

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Resolution beyond money

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 transplant 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.”

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
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 Claims
University of Illinois Hospital and Health Sciences System

Number of Claims

Time (Quarterly from July 2000 to September 2011)
Premiums over time

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

![Graph showing the effects of Seven Pillars on Self Insurance Total Funding Needed.](image-url)
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

- 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.

1. Identification of CANDOR Event
2. CANDOR System Activation
3. Response/Disclosure
4. Investigation
5. Resolution
Work with Kettering

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