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The University of Michigan Claims Experience: Disclosure, Communication, and Patient Safety

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Agenda/Outline

- UMHS: Background & Approach to Claims and Patient Safety
- UM Claims Management Principles & Model
- Managing Patient Expectations: Beginning to End
- 6 Key Program Components
- Disclosure as a Process, Not a Single Event
- JW's Story
- Observations & Lessons Learned

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- 3 hospitals, 30 health centers, 120 outpatient clinics
- 913 licensed beds
- 18,298 faculty & staff
- 1,050 residents & interns, 3,319 RNs
- & Chief Risk Officer, Richard C. Boothman

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Change Started with a Shift in Priorities at UMHS

- Focus on patient safety vs. fear of litigation
- Focus on communication: often our own behavior drives patients to get a lawyer
- Focus on principled response to adverse outcomes, patient complaints and patient claims

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UM Claims Management Principles

We will compensate quickly and fairly when inappropriate medical care causes injury.

We will defend appropriate care.

We will reduce patient injuries (and claims) by learning from mistakes.

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- Cannot claim that transparency caused the drop in our claims
- Can say that transparency has NOT been the calamity everyone predicted
- Can say that a principled approach and a culture of transparency is necessary for robust patient safety improvement

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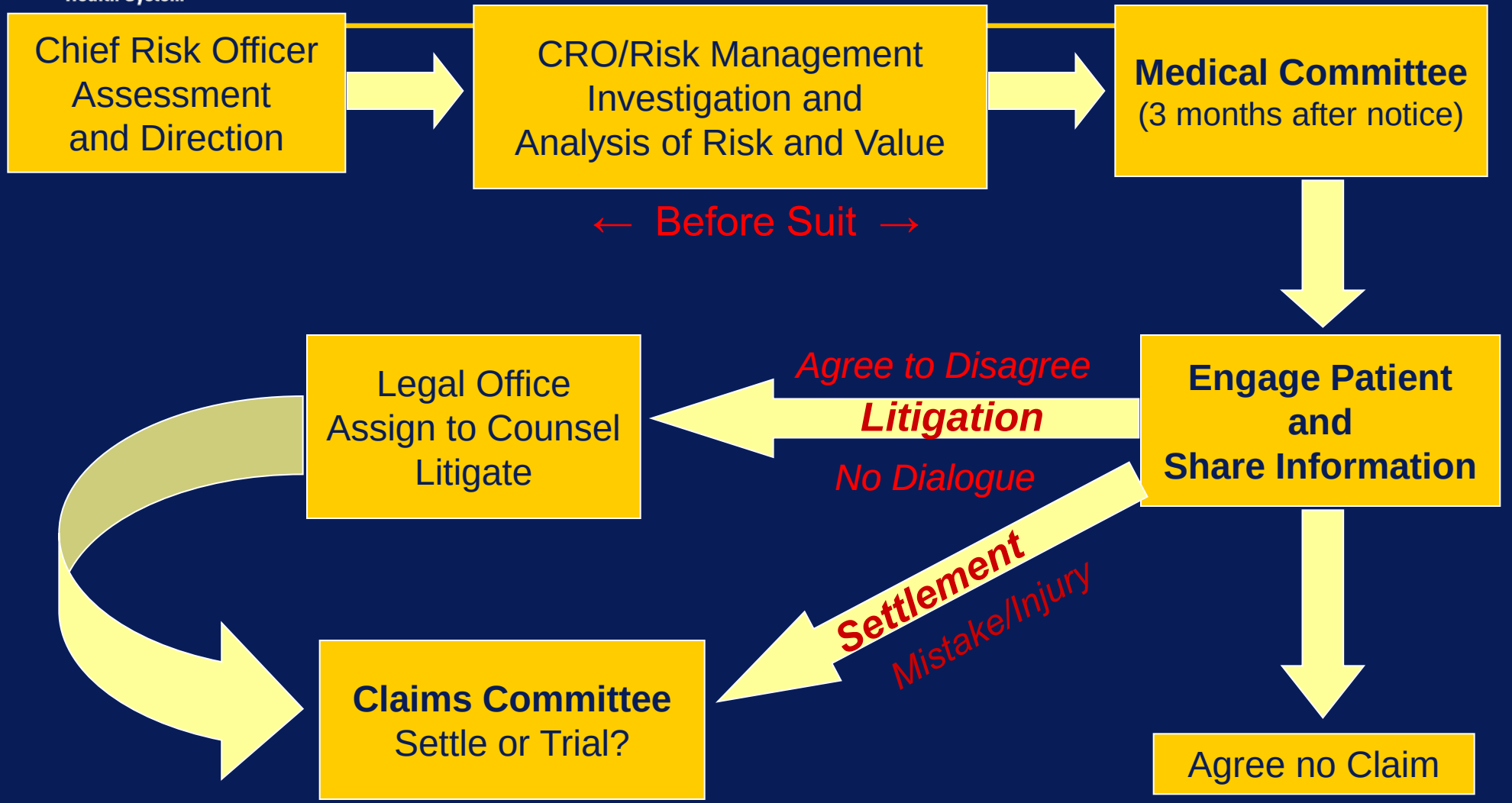
U of M Claims Management Model



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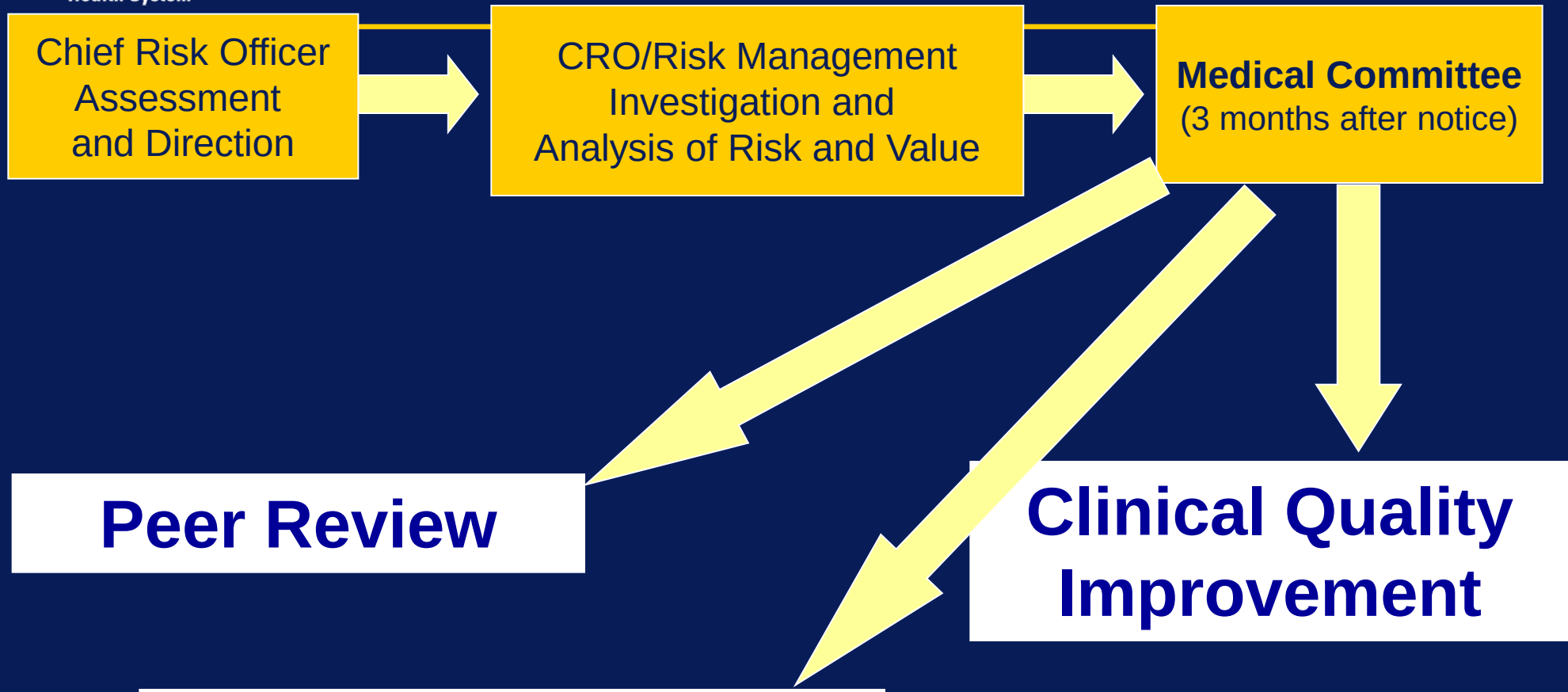
Pre Suit Investigation



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Mindful vs Mindless Messages

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We create expectations we cannot fulfill through thoughtlessness remarks, lack of common sense, arrogance, paternalism, misguided compassion etc. . .

. . . and then we wonder why patients are upset over unexpected outcomes.

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Managing Expectations

"You shouldn't have any problems whatsoever with this surgery...you'll be up and running in no time..." *UMHS Cardiac Surgeon*

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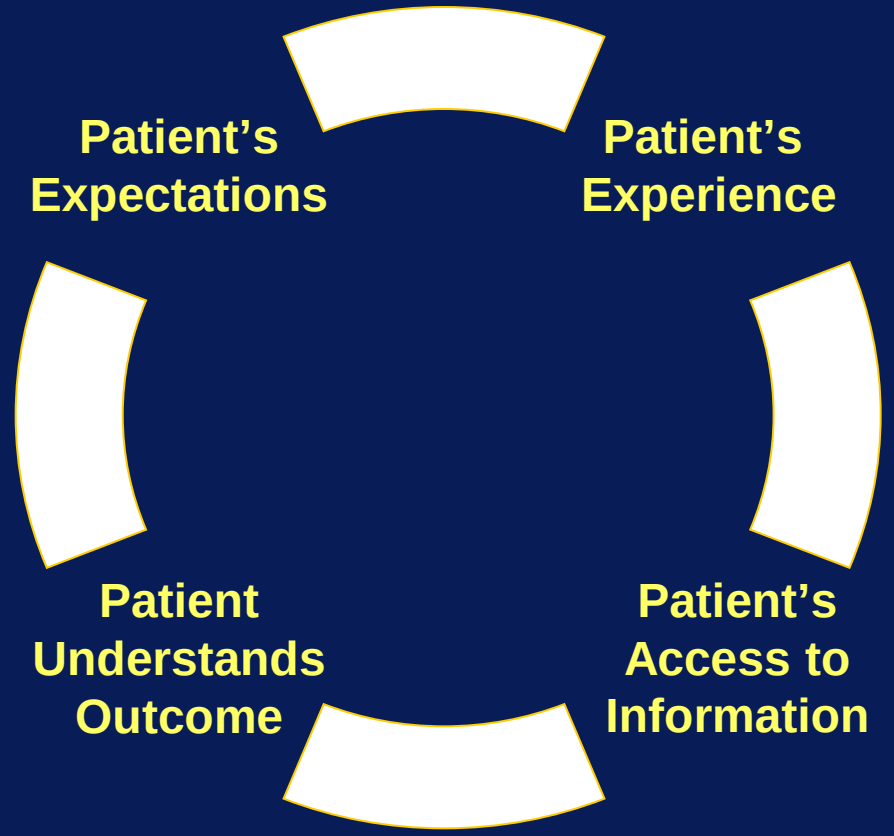

Interrupting this cycle increases the risk that patients will turn to lawyers.

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UMHS Program: 6 Components

1. **Catchment device for early reporting**: consider low-tech methods
2. **Assessment:** In a dangerous world, no guarantees even if care is reasonable.
3. **Protection**: Not fair to ask providers to do what we ask them to and hold financial ruin over their heads if things go badly.

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UMHS Program: 6 Components

4. **Communications**: mechanism/resource for healthcare providers when things go badly
5. **Measurement**: where are the problems & are they a trend...are you making a difference?
6. **Accountability**: Org needs to say they own the problem & will compensate when there's an error & we'll fix it

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Disclosure as a Process

- Begins with informed consent
- Info can change as it comes in
- Keep communication lines open
- Be mindful of how those involved are affected – offer support, counseling if necessary

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JW's Story

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Two and a half year delay in diagnosing breast cancer in 36 year old woman, causing need for more extensive surgery, chemotherapy, chronic fatigue, lost chance for cure, lost wages, disability, pain, suffering

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Timeline and Conversations

- Assessment of care not entirely black & white
- 3 reviewers said no f/u with mammogram was violation of standard of care, 2 others hesitantly offered to testify otherwise
- Litigation: costly, eliminate discussions with plaintiff, patient, physicians, hospital
- Decision: Internal/external expert reviews – apology sent
- Offered meeting w/MD, patient, lawyers
- Meeting held, disclosed course of events, reviews and offered full explanation

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Final Points/Lessons Learned

- We continue to evolve, refine, be humbled
- Patient safety is the overriding principle
- Disclosure is a process, not an event
- Support/coach involved clinicians
- Start small, pilot, publish
- Don’t make assumptions
- Share patient stories: internally, externally

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Questions?

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