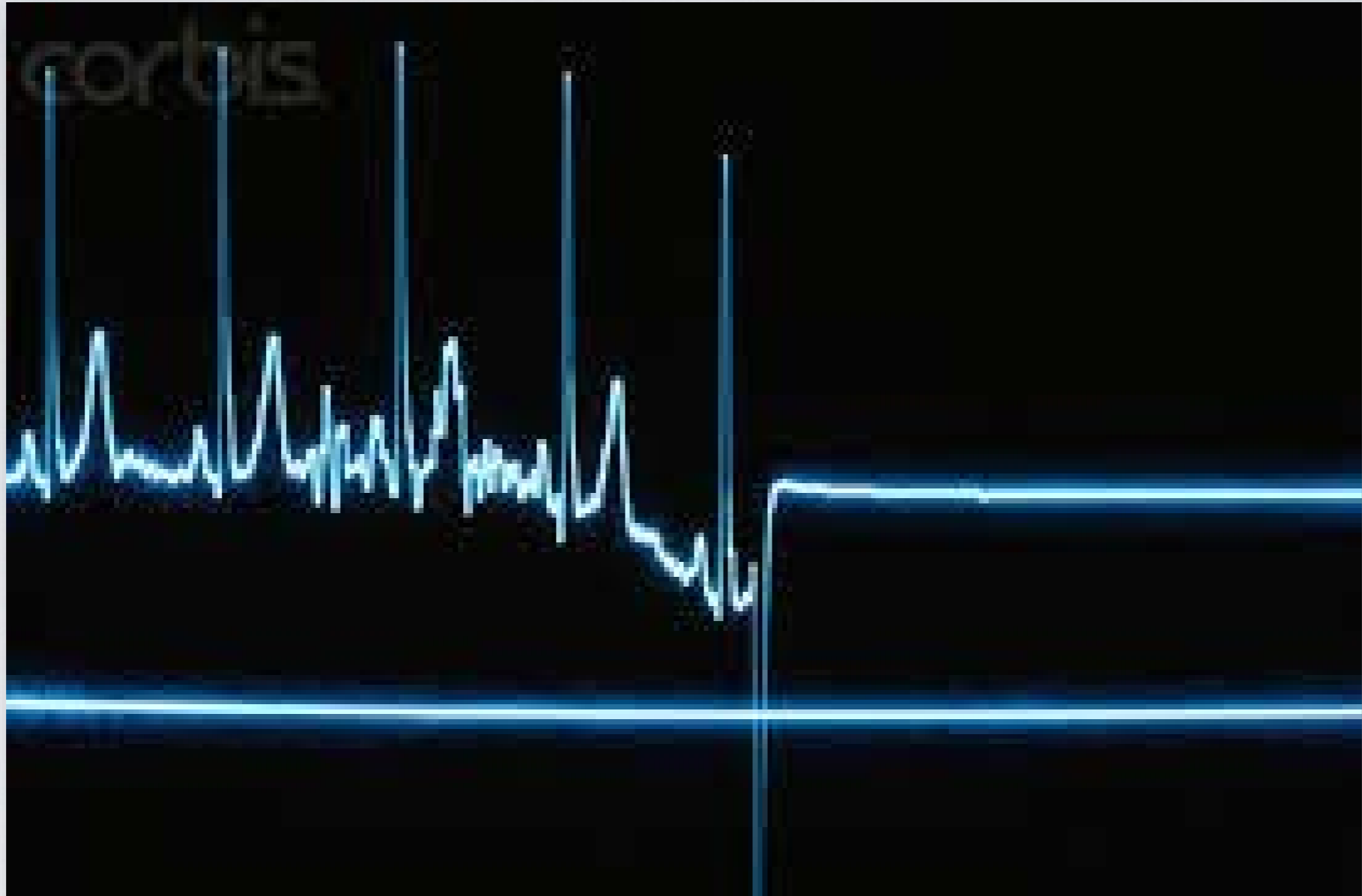


After the Unexpected: Disclosure, Transparency & Collaboration

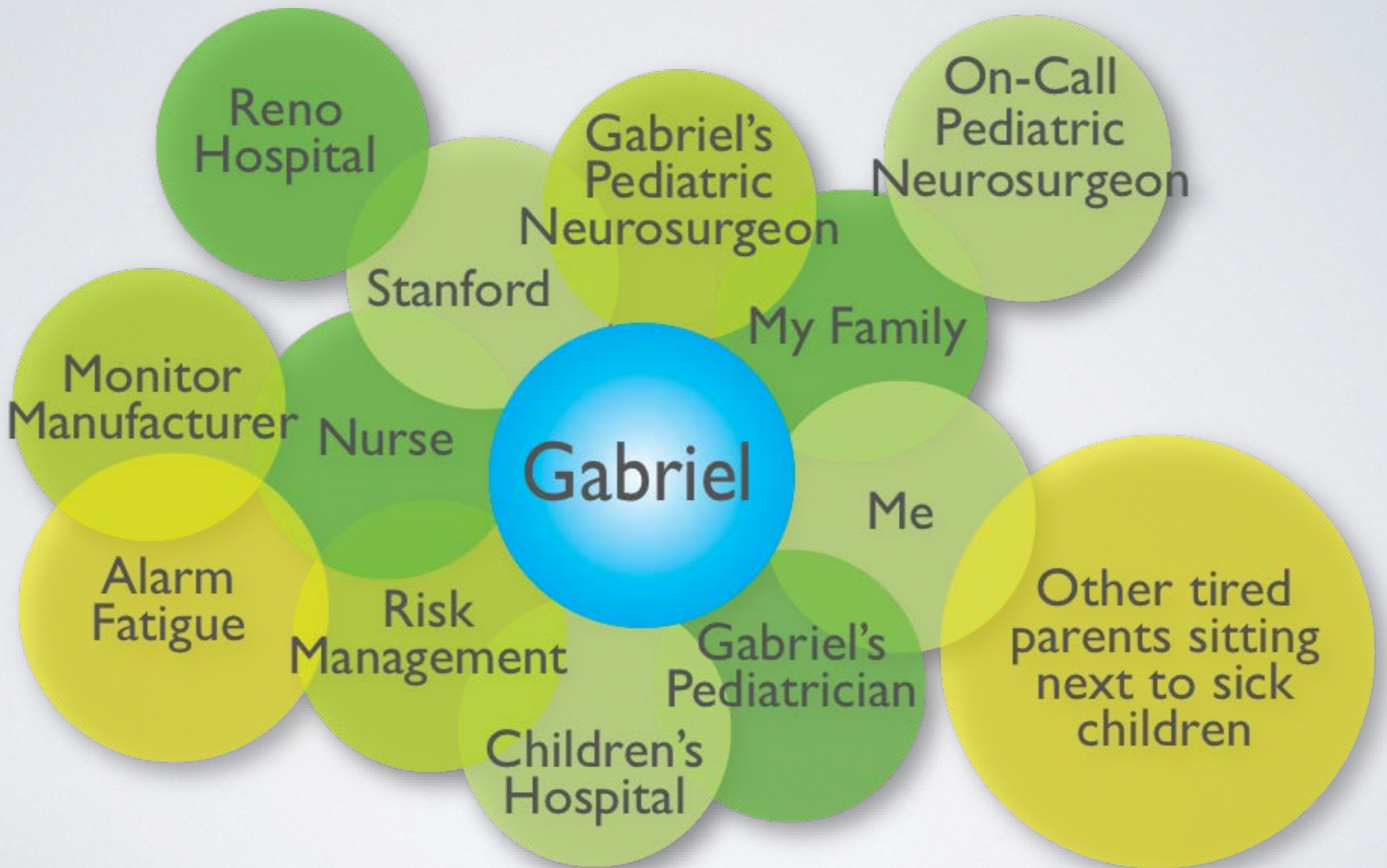
Leilani Schweitzer













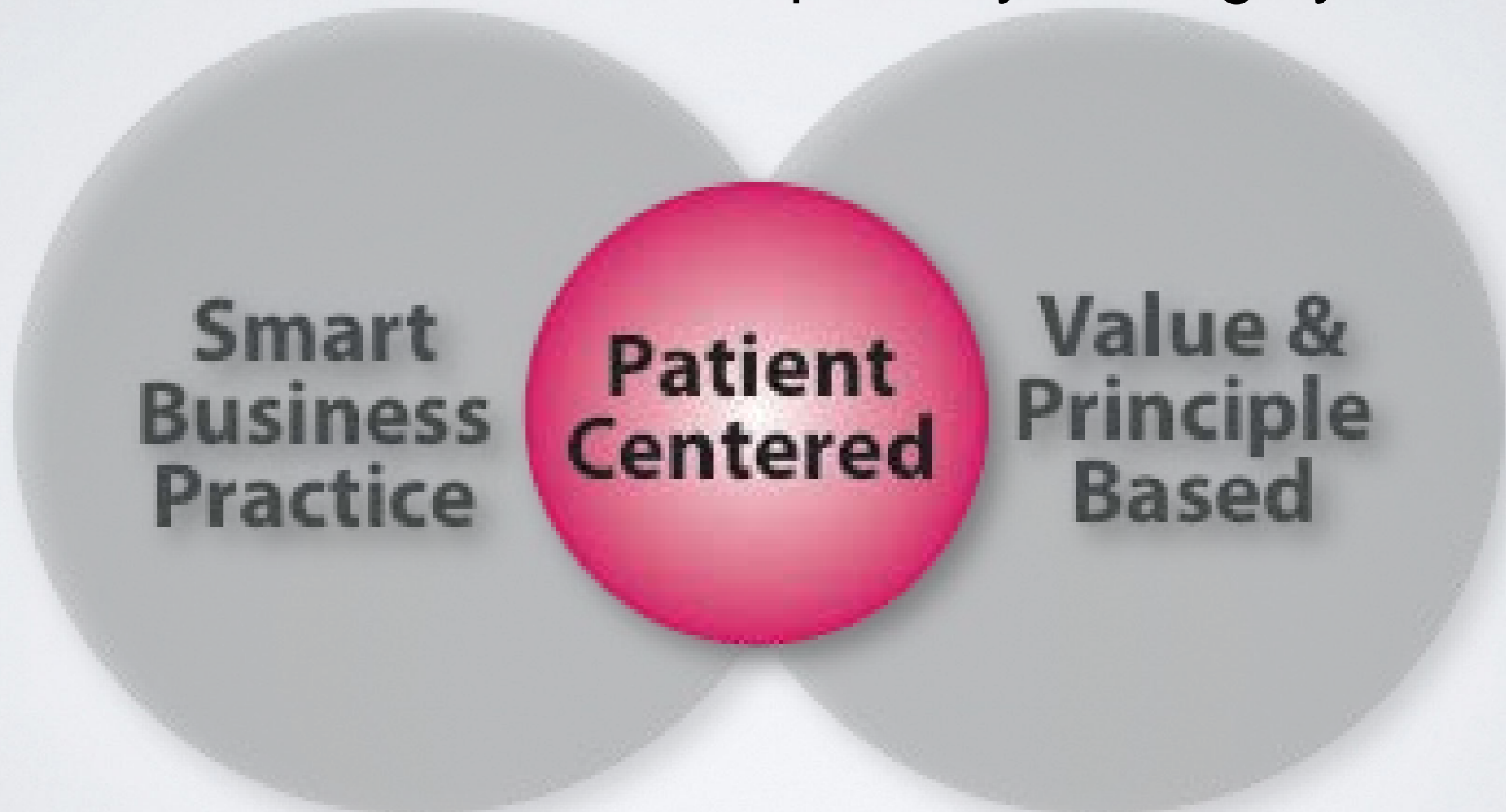
No Longer Practicing Medicine

I am one of the lucky ones.

PEARL:

A Hybrid Values & Claims Centric Model

PEARL is based on the fundamentals of communication, transparency & integrity.



EARLY R'S

Early Recognition

Early Response

Early Review

Early Resolution

WHAT IS A PEARL?

- Significant
 - Adverse
 - Unexpected
- Medical Outcome**

PEARL:

- Death
- Short Term Disability
- Long Term Disability

PEARL provides:

Patients want:

- Explanation
- Full Apology
 - Recognition
 - Responsibility
 - Amends
- Improvements

Hospitals want:

- Explanation
- Accountability
- Improvements

Claims Specialist (internal)

+

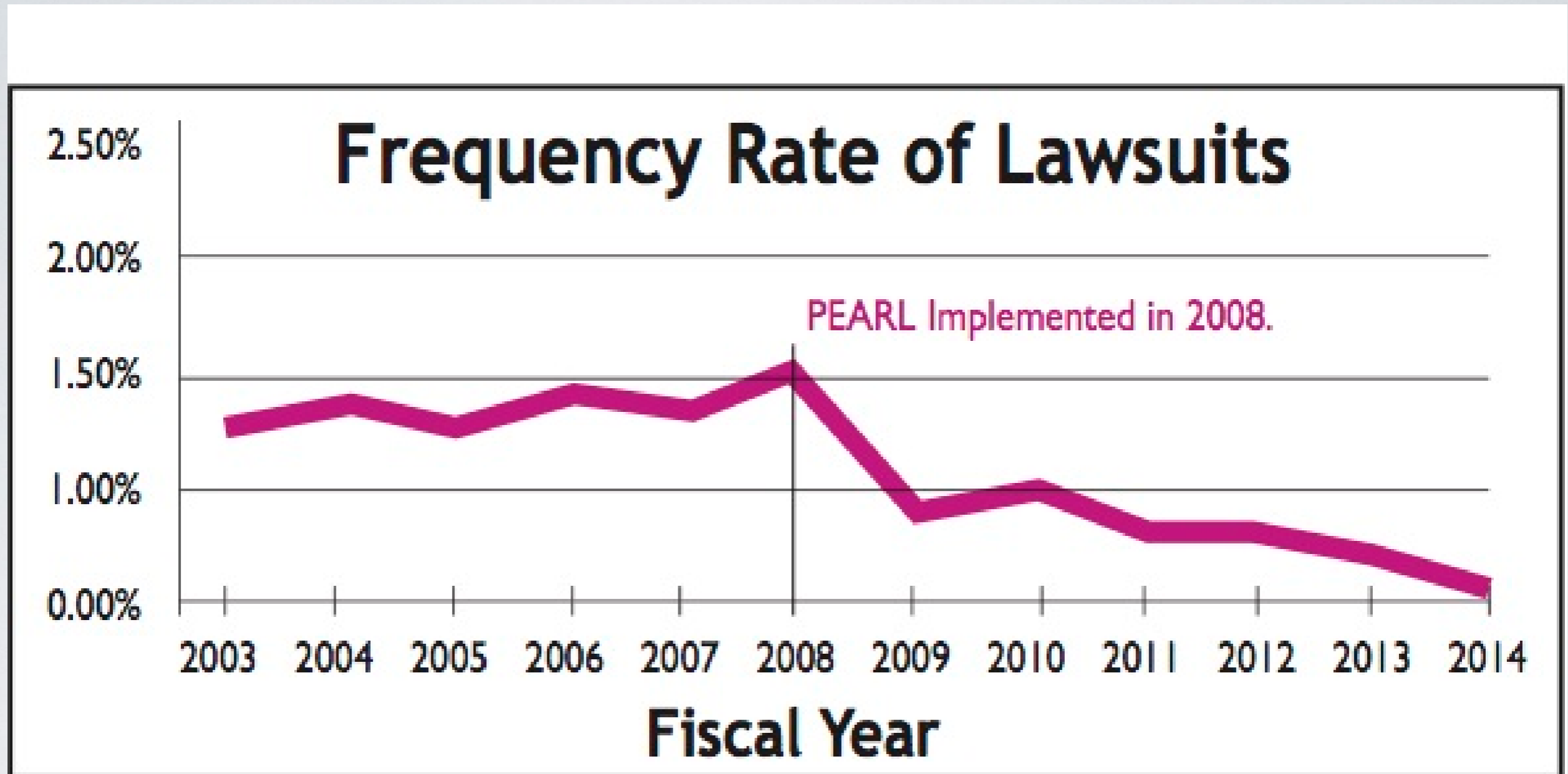
Patient Liaison (external)

= PEARL

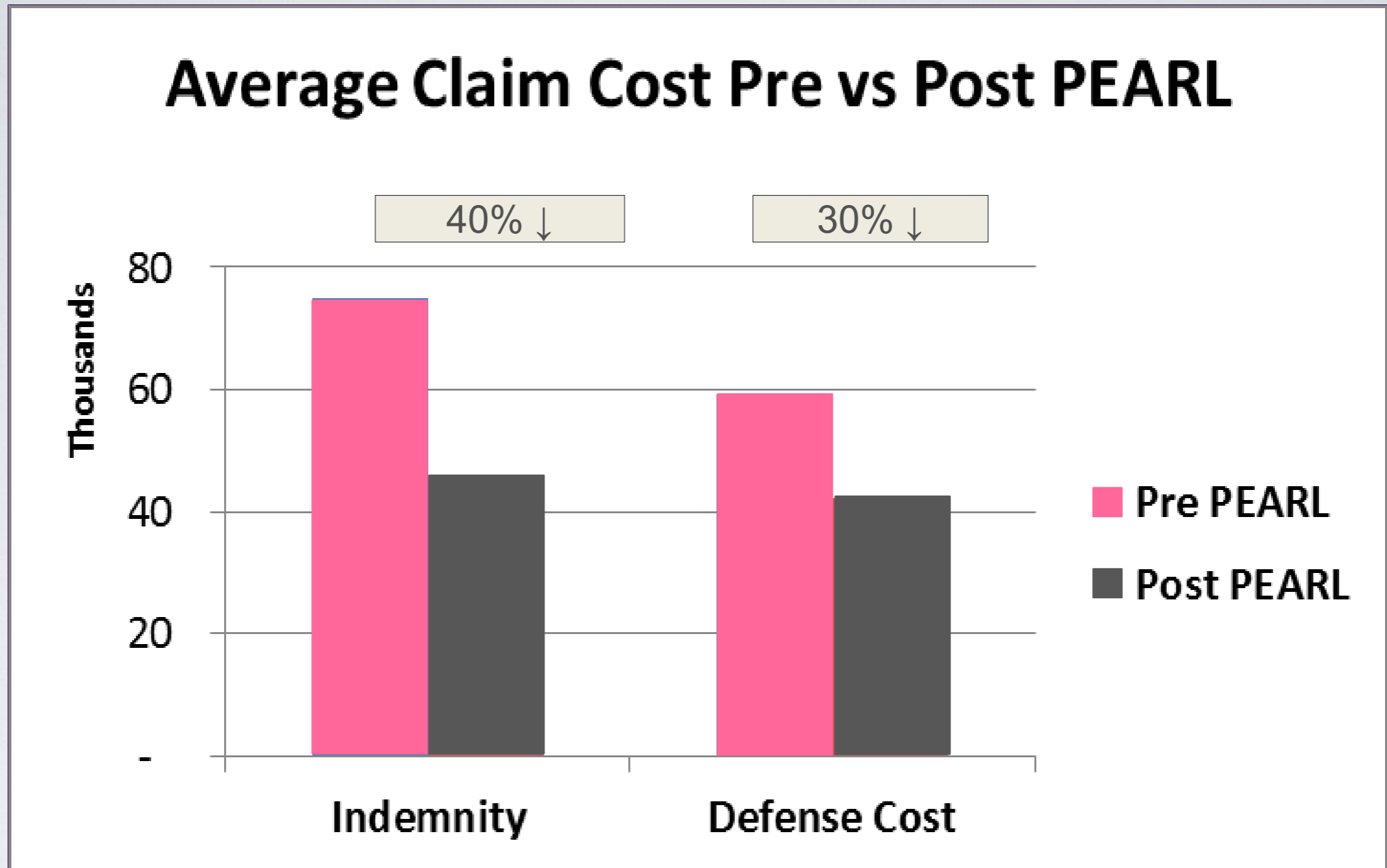
PEARL Patient Liaison

- Guide the Patient & Loved Ones
- Single point of contact
- Set Expectations
- Advocate for the Patient on the Claims Team

TRA Results



TRA Results



Note: Only includes claims with indemnity > \$1,000

In addition, defense cost on PEARL cases are 20% lower than non-PEARL cases.

PEARL Results

Metric	Desired Result	Observed Result	Basis
Lawsuit Frequency	Lower	Lower	Pre vs Post PEARL
Average Claim Severity	Lower	Lower (inconclusive in 2013)	Pre vs Post PEARL
Average Defense Costs (ALAE) Severity	Lower	Lower	Pre vs Post PEARL
Closing	Faster	<u>Unchange</u>	Pre vs Post

Pre PEARL period: FY 2003 to 2008
 Post PEARL period: FY 2009 to 2014

TRA Results

First 3.5 years of PEARL

Claim frequency down 36%

Saving \$3.2 Million/year

Truth & Compassion
=
Good Business

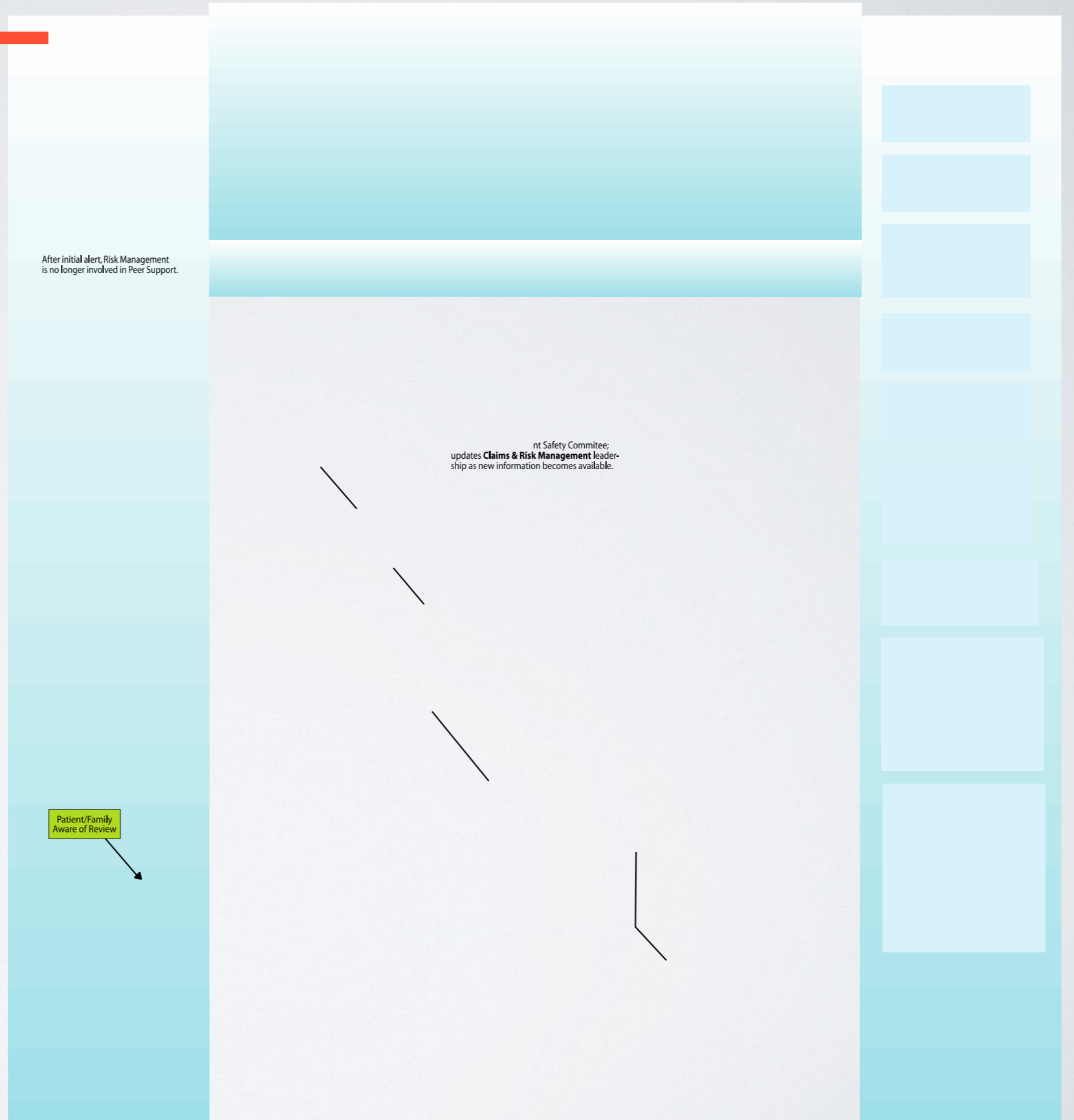
Impossible to do
Nothing.

PEARL Map

After initial alert, Risk Management
is no longer involved in Peer Support.

nt Safety Committee;
updates **Claims & Risk Management** leader-
ship as new information becomes available.

Patient/Family
Aware of Review





When Doctors Admit Their Mistakes

By Peter H. Lee, MD, MPH
After a patient's death, I conducted a post-mortem analysis of the case. I was surprised to find that the medical team had not admitted their mistakes. This is a common problem in the medical profession. Doctors often feel that admitting a mistake will reflect poorly on their competence. However, admitting a mistake is a sign of maturity and a willingness to learn from the experience. It is also a way to build trust with patients and their families. In this article, I discuss the importance of admitting mistakes and provide some tips for how to do it effectively.

Who's Sorry Now?

By David G. Green
The medical profession has a long history of covering up mistakes. This is a dangerous practice that can lead to further harm for patients. It is time for the medical profession to change its culture and embrace transparency. Admitting mistakes is not a sign of weakness; it is a sign of strength. It shows that you are willing to take responsibility for your actions and to learn from your mistakes. In this article, I discuss the importance of admitting mistakes and provide some tips for how to do it effectively.

PEDIATRICS

Half and Half Perspectives Regarding Quality of Pediatric Palliative Care
A. Green, J. Smith, S. Jones, B. Brown, C. White, D. Black, E. Gray, F. Blue, G. Red, H. Purple, I. Orange, J. Yellow, K. Green, L. Blue, M. Red, N. Purple, O. Orange, P. Yellow, Q. Green, R. Blue, S. Red, T. Purple, U. Orange, V. Yellow, W. Green, X. Blue, Y. Red, Z. Purple
This information is current as of November 14, 2014.
The online version of this article, along with updated information and services, is located on the World Wide Web at <http://www.pediatrics.org/cgi/doi/10.1542/peds.2014.253.0011>

American Academy of Pediatrics
PEDIATRICS
Official Journal of the American Academy of Pediatrics
Volume 134, Number 5, May 2014

Opportunities for Quality Improvement in Bereavement Care at a Children's Hospital: Assessment of interdisciplinary staff perspectives

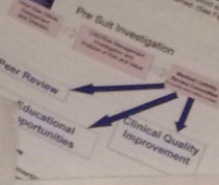
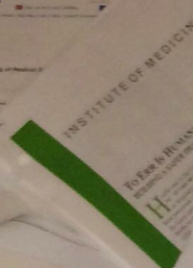
By Robert A. Chertoff, MD, MPH, Larry R. Brown, MD, and Barry D. Stein, MD, MPH
Bereavement care is a critical component of pediatric palliative care. However, there are many challenges to providing high-quality bereavement care. In this article, we discuss the importance of bereavement care and provide some tips for how to improve it. We also discuss the perspectives of interdisciplinary staff on this issue.

The Francis Report

by The Joint Commission
The Francis Report is a landmark document that has shaped the future of patient safety. It is a call to action for the medical profession to improve patient safety and quality of care. In this article, we discuss the key findings of the Francis Report and provide some tips for how to implement its recommendations.

Reporting Adverse Events to Patients: A Step-by-Step Approach

By Robert A. Chertoff, MD, MPH, Larry R. Brown, MD, and Barry D. Stein, MD, MPH
Reporting adverse events to patients is a challenging task. However, it is a critical component of patient safety. In this article, we provide a step-by-step approach to reporting adverse events to patients. We also discuss the importance of transparency and the benefits of reporting adverse events to patients.



MILLS & REEVE



Click here to find out more
6/18/2014

Two Questions:

What would happen at your hospital if a child died because of an error?

What would you want to happen if that child was yours?





Unintended Errors
vs.
Deliberate Choices

gone out in blizzards.”

On weekends, he goes to a nearby state park and will skate ski or cross-country ski 10 to 15 miles.

then hops on one leg across a room, pausing to hold the landing of each hop along the way. Other exercises include leg lifts, opposite

of walking, with a glide phase,” says Ms. Stuber. “With little to no instruction, someone can put waxless classic skis on their feet and move down the

str
go
hit
yo



Leilani Schweitzer, left, and Abdul Hamamsy, right, risk management officials, met with Gary Avila after a nerve was nicked during surgery on his arm at Stanford Hospital, in Palo Alto, Calif.

ERRORS

Continued from page D1
cludes learning from adverse events, than “loss.”

tion programs through training seminars.

The federal Agency for Healthcare Research and Quality has funded several communication and resolution demonstration

financial compensation to patients who experienced harm or distress, even if an investigation determines the standard of care was met.

At Stanford, patients may

Patients like Mr. Avila at Stanford often hear from someone who has been in their shoes—Leilani Schweitzer, assistant president for communication and resolution.

Ms. Schweitzer’s month-old son, Gabriel, died of complications from a brain aneurysm, or water on the brain, at Stanford’s hospital in 2005, when the Pearl program was just getting started.

An investigation by a nurse turned off an alarm system, thinking it would be a nuisance only in his room so his mother could sleep.

But because of the confusion with the alarm-system programming, it was turned off at the time of the operation. As a result, Gabriel came to Gabriel’s death, a shunt in his brain leading his heart to stop beating.

Despite her deep grief, Ms. Schweitzer says she was struck

DOUGLAS PECK/TRIA STANFORD

Disclosure & Transparency
= Standard of Care





Thank you.

Leilani Schweitzer

lschweitzer@theriskauthority.com