May 16th, 10:15 AM

Patient-Perceived Breakdowns in Care: Informing Clinician Responses

Kimberly A. Fisher
University of Massachusetts Medical School

Follow this and additional works at: https://escholarship.umassmed.edu/cts_retreat

Part of the Critical Care Commons, Health Services Administration Commons, Health Services Research Commons, and the Translational Medical Research Commons

This work is licensed under a Creative Commons Attribution-Noncommercial-Share Alike 3.0 License.

https://escholarship.umassmed.edu/cts_retreat/2017/program/10

This material is brought to you by eScholarship@UMMS. It has been accepted for inclusion in UMass Center for Clinical and Translational Science Research Retreat by an authorized administrator of eScholarship@UMMS. For more information, please contact Lisa.Palmer@umassmed.edu.
Patient-Perceived Breakdowns in Care: Informing Clinician Responses

Kimberly A. Fisher, MD, MSc
Assistant Professor of Medicine, Pulmonary/Critical Care Medicine
University of Massachusetts Medical School, Worcester, MA
Meyers Primary Care Institute, Worcester, MA
Disclosures

Grant Support

- AHRQ 5 K08 HS024596-02 (Fisher)

No conflicts to report.
What is a patient-perceived breakdown in care?

- Any event in which something “went wrong” in care from the perspective of the patient or the family member
- In some studies, definition includes that event was preventable and resulted in harm (impact) to the patient
- Not all (in fact, most) patient-perceived breakdowns may not meet “traditional” definition of medical error
### Types of patient-perceived breakdowns

<table>
<thead>
<tr>
<th>Type of breakdown</th>
<th>Total = 979</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information exchange</strong> (insufficient information; providers not listening to patient; difficulty getting questions answered)</td>
<td>158 (16.1)</td>
</tr>
<tr>
<td>Medication-related (pain control), side effects, wrong meds, med admin</td>
<td>120 (12.3)</td>
</tr>
<tr>
<td>Access and relationship with provider (no/suboptimal access to provider; providers with rude manner)</td>
<td>100 (10.2)</td>
</tr>
<tr>
<td>Admission process (long wait on admission)</td>
<td>90 (9.2)</td>
</tr>
<tr>
<td>Team communication</td>
<td>65 (6.6)</td>
</tr>
<tr>
<td>Nursing care and responsiveness</td>
<td>63 (6.4)</td>
</tr>
<tr>
<td>Discharge (timing, arrangements, information)</td>
<td>56 (5.7)</td>
</tr>
<tr>
<td>Treatment (not available, too aggressive, not appropriate)</td>
<td>34 (3.5)</td>
</tr>
<tr>
<td>Diagnosis (delayed, no diagnosis, conflicting diagnoses)</td>
<td>33 (3.4)</td>
</tr>
<tr>
<td>Testing (not offered/available, delayed, denied)</td>
<td>21 (2.1)</td>
</tr>
</tbody>
</table>

Some examples from the ICU of surrogate-DM difficulty getting information

“I didn't have a really clear idea of who to go to for information.”

“I had asked them multiple times for more information and paperwork. And they didn't give it to me.”

“I thought there was little silos of information.”

Why are patient-perceived breakdowns in care important? (they are common)

<table>
<thead>
<tr>
<th>Population</th>
<th>Clinical sites (n)</th>
<th>N screened</th>
<th>Breakdown reported, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients treated for cancer</td>
<td>3</td>
<td>416</td>
<td>93 (22.4)</td>
</tr>
<tr>
<td>SDMs of critically ill patients</td>
<td>1</td>
<td>70</td>
<td>32 (45.7)</td>
</tr>
<tr>
<td>Hospitalized patients</td>
<td>2</td>
<td>979</td>
<td>386 (39.4)</td>
</tr>
</tbody>
</table>

Fisher et al., J Hosp Med. 2017, (accepted for publication).
Why are patient-perceived breakdowns in care important? (they are harmful)

- Impact of breakdowns in care (as reported by patients)
  - Physical harm (includes pain)
  - Emotional distress (worry, anger, frustration)
  - Damaged relationship with providers (care avoidance)
  - Need for additional medical care (prolonged hospital stay or re-hospitalization)
  - Provision of healthcare not in keeping with patient’s preferences
  - Disruption to patient’s or family member’s life
  - Impaired decision-making ability
  - Financial costs to patient
Impact of patient perceived-breakdowns on decision making

“I’m responsible for his medical decisions when he’s in that situation. I need to have all this information. I need to not have conflicting statements constantly. You don’t know what to do.”

“I can't think of anything specifically that went wrong, other than her being intubated in the first place. My mom has always said she never wanted to be intubated.

How can patient-perceived breakdowns in care be used to improve healthcare?

- Systematic reporting of patient-perceived breakdowns (HCAHPS)
- Identify common breakdowns
- Target system-level improvements
- Encourage patient to speak up
- Provider response to patient
- Patient-perceived breakdown
How do patients want providers to respond?

“Now I understand. I get that. All you have to do is just let me know. Let me be on the same page.”

“It definitely helped that she was apologetic.”

Patients receive fully and satisfactory response in ~ 25% events

How do providers frequently respond?

Limited response in ~ 50% events

“One of the nurses found a doctor to talk to me. But it wasn’t sort of a person who knew completely about her care. It just happened to be the resident who was on the unit at that time.”

Hostile or no response ~ 25% events

“When I questioned the doctor he got kind of belligerent with me.”

Conclusions

• Patient-perceived breakdowns in care are common and harmful events

• Interventions to address patient-perceived breakdowns are needed to make healthcare more patient-centered

• Provider engagement will be required to effectively address patient-perceived breakdowns in care
  – Need to understand provider perspective of patient-perceived breakdowns in care and factors that influence their response
  – Develop interventions (communication skills training, apology training)
Thank you.

Kimberly.Fisher@umassmemorial.org