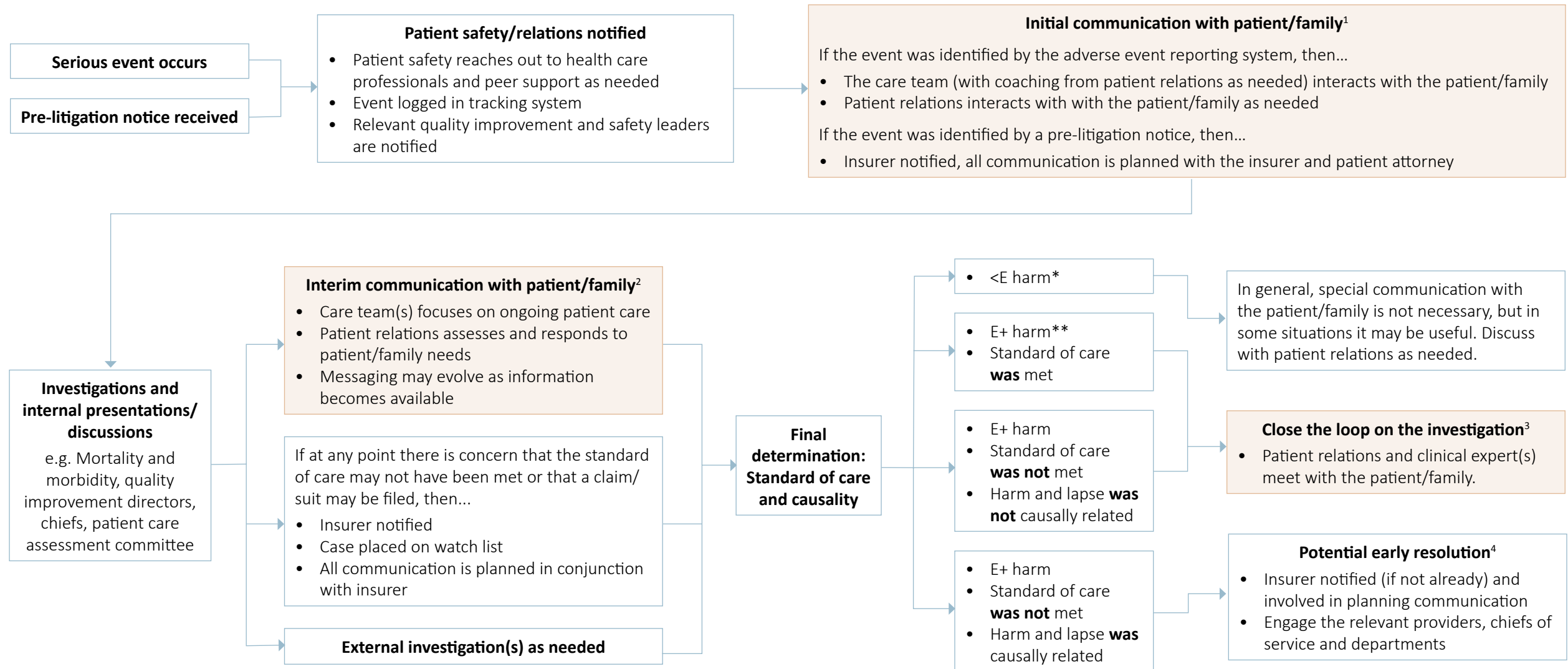


# Clinician care communication algorithm

## COMMUNICATION, APOLOGY AND RESOLUTION (CARE)



\*Using NCC-MERP scale as letter reference

\*\*Minor temporary harm to the individual that required intervention of <3 follow up visits and did not require an additional procedure

### <sup>1</sup>Initial communication with patient/family

- Care team (with coaching from patient relations as needed) interacts with the patient/family

#### DO SAY

- *“We are so sorry this happened to you.”*
- *“We’re not yet sure why this happened.”*
- *“We are going to do an investigation to try to figure out why this happened.”*
- *“We will be in touch once we have learned more.”*
- *“Right now, our primary focus is on making sure you get the care you need.”*
- *“We are going to connect you with someone in patient relations who you can contact at any time. They can help you get in touch with us and get answers to other questions you may have.”*

#### DON'T SAY

- *“We have been in touch with our risk manager/insurer.”*
  - Don't speculate, e.g. *“We’re not sure you needed that procedure”* or *“That other hospital didn’t know what they were doing.”*
- Patient relations interacts with patient/family as needed
    - Express empathy and reiterate your role and contact information.
    - If uncertain about whether the standard of care was met, consider early service recovery, e.g. paying for parking.
    - The patient/family may indicate they do not want to be contacted by patient relations, or they may simply not respond to outreach. In the latter situation, patient relations should stop attempting to contact them after two phone calls and one letter asking them to reach out when ready.

### <sup>2</sup>Interim communications with patient/family

- Care team focuses on ongoing patient care
  - Communication stays focused on current state and future care, not on the adverse event. See prior tips about DOs and DON'Ts for initial communication. Direct questions about the investigation to patient relations.
- Patient relations interacts with patient/family as needed

#### DO SAY

- *“How are you doing?”*
- *“Is there anything we can do to facilitate your care?”*
- *“We are continuing to look into why this happened.”*
- *“We want to be very thorough in our investigation so we can prevent this from happening again.”*
- NOTE: If there are indications that the standard of care was not met, additional early service recovery may be indicated

#### DON'T SAY

- *“It takes a really long time for these cases to be reviewed.”*
- Situations where it is unclear whether the standard of care was met, or where it's unclear if lapses in the standard of care were causally related to the harm, can be particularly complex and may take a longer time to make a final determination. In such situations:

#### DO SAY

- *“We want to be very thorough in our investigation so we can prevent this from happening again.”*
- *“We take these events very seriously and want to give your event the time and attention it deserves. We expect to be done with the comprehensive review in about [x weeks] but I will let you know if that changes.”*

### <sup>3</sup> Close the loop on the investigation

- Patient relations and clinical expert(s) meet with patient/family

#### DO SAY

- *“Thank you for coming to meet with us. We would like to share the results of our investigation into what happened and make sure we address any questions you might have.”*
- Explain what happened in matter-of-fact, patient-centered language. Pause to allow opportunities for questions.

- E+ harm
- Standard of care **was met**

#### DO SAY

- *“Unfortunately, our investigation determined there was no way to prevent what happened to you.”*
- *“As a result of this case, we recognized an opportunity to make some improvements. They wouldn’t have prevented what happened to you, but they may help prevent harm to other patients.”*
- *“We’re so sorry this happened to you.”*
- After the meeting, provide a written summary of the clinical details that were discussed.

- E+ harm
- Standard of care **was not met**
- Harm and lapse **was not** causally related

#### DO SAY

- *“Unfortunately, our investigation determined that while we wish we had done some things differently, the harm you experienced was not preventable.”*
- *“In other words, even if your care had been flawless, we believe you still would have experienced what you did.”*
- *“As a result of this case, we recognized an opportunity to make some improvements. They wouldn’t have prevented what happened to you, but they may help prevent harm to other patients.”*
- *“We’re so sorry this happened to you.”*
- After the meeting, provide a written summary of the clinical details that were discussed.

Usually one such conversation is sufficient. In some situations, additional meetings with patients/families may be needed if they think of more questions.

- E+ harm
- Standard of care **was not met**
- Harm and lapse **was** causally related

#### <sup>4</sup> Potential early resolution

- Insurer notified (if not already), and involved in planning communication
- Engage the relevant providers, chiefs of service and departments

If all agree with proceeding with early resolution program, then...

#### DO SAY

- *“In summary, our investigation determined that your experience may have been preventable [based on particular circumstances of case].”*
- *“We’re making changes to help prevent future patients from experiencing what you did.”*
- A patient relations and/or patient safety representative discusses the CARE program insurer review and possible compensation with the patient/family. Such discussions usually take place at the end of this meeting, and clinicians are typically not present.

Future communication is between the patient/family (+/- their attorney) and the insurance claims rep (+/- others as needed)

If there is disagreement on proceeding with early resolution, then...

- Begin typical malpractice pathway

If there is disagreement about the valuation of harm, then...

- Attempt mediation

**<sup>3</sup> Close the loop on the investigation**

- Patient relations and clinical expert(s) meet with patient/family

**DO SAY**

- *“Thank you for coming to meet with us. We would like to share the results of our investigation into what happened and make sure we address any questions you might have.”*
- Explain what happened in matter-of-fact, patient-centered language. Pause to allow opportunities for questions.

**88%**

- E+ harm
- Standard of care **was** met

**DO SAY**

- *“Unfortunately, our investigation determined there was no way to prevent what happened to you.”*
- *“As a result of this case, we recognized an opportunity to make some improvements. They wouldn’t have prevented what happened to you, but they may help prevent harm to other patients.”*
- *“We’re so sorry this happened to you.”*
- After the meeting, provide a written summary of the clinical details that were discussed.

**2%**

- E+ harm
- Standard of care **was not** met
- Harm and lapse **was not** causally related

**DO SAY**

- *“Unfortunately, our investigation determined that while we wish we had done some things differently, the harm you experienced was not preventable.”*
- *“In other words, even if your care had been flawless, we believe you still would have experienced what you did.”*
- *“As a result of this case, we recognized an opportunity to make some improvements. They wouldn’t have prevented what happened to you, but they may help prevent harm to other patients.”*
- *“We’re so sorry this happened to you.”*
- After the meeting, provide a written summary of the clinical details that were discussed.

**10%**

- E+ harm
- Standard of care **was not** met
- Harm and lapse **was** causally related

**<sup>4</sup> Potential early resolution**

- Insurer notified (if not already), and involved in planning communication
- Engage the relevant providers, chiefs of service and departments

If all agree with proceeding with early resolution program, then...

**DO SAY**

- *“In summary, our investigation determined that your experience may have been preventable [based on particular circumstances of case].”*
- *“We’re making changes to help prevent future patients from experiencing what you did.”*
- A patient relations and/or patient safety representative discusses the CARE program insurer review and possible compensation with the patient/family. Such discussions usually take place at the end of this meeting, and clinicians are typically not present.

Usually one such conversation is sufficient. In some situations, additional meetings with patients/families may be needed if they think of more questions.

Future communication is between the patient/family (+/- their attorney) and the insurance claims rep (+/- others as needed)

- If there is disagreement on proceeding with early resolution, then...
- Begin typical malpractice pathway

- If there is disagreement about the valuation of harm, then...
- Attempt mediation

Data based on two academic medical center sites over one year; percentages similar to data from other sites in three-year pilot study.