Implementation guide

COMMUNICATION, APOLOGY AND RESOLUTION (CARe)

What is CARe?

Communication, Apology and Resolution (CARe) is an alternative to costly, lengthy, and emotionally difficult lawsuits after a medical injury. This approach improves patient safety, reduces costs, and enhances fairness and transparency in medical care.

Health care organizations that adopt CARe commit to prompt and open communication with patients and families after an adverse event, as well as support for clinicians throughout the process. If the event was found to be preventable, patients and families are offered a sincere apology and financial compensation.

This model, adopted by hundreds of health care facilities across the country, also advances patient safety by capturing information about harm events so providers and facilities can learn and prevent recurrences of adverse events.

This guide lays out the important steps for implementing CARe at your institution and includes helpful resources to assist you in this task.

While we hope this guide is helpful, there is no substitute for personal assistance and interactive discussion around the process to make sure that it fits your institution well. Therefore, we recommend any organization looking to implement the CARe model contact us for consultation and support.

The CARe initiative was previously led by the Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) until June 2022, and is now managed by the Betsy Lehman Center for Patient Safety. The resources found in this guide, as well as additional tools and research, can be found at BetsyLehmanCenterMA.gov/CARe. For more information and assistance, please contact Melinda Van Niel at Melinda.VanNiel@BetsyLehmanCenterMA.gov.

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INSTITUTIONAL PREPARATION

1. Use the readiness checklist to ensure that your institution has the baseline culture and support it needs to implement the CARe model successfully.
2. Create a timeline of the implementation steps in this guide so you can realistically set a target date for official CARe launch.
3. Review the CARe policy template, modify it as appropriate for your institution, and take steps to certify this policy in your organization so that it replaces or adds to existing policies about adverse events.
4. Urge your supportive leadership to mention the program and its target implementation date at relevant meetings.
5. Work with risk management and patient safety to make sure that everyone understands the CARe philosophy and that this effort requires working together as a team to make this cultural change in the institution. It will take time and hard work, but it is worth it!

THE DAILY WORK

1. Map your current case review process for incidents reported internally and via a patient concern (what groups are involved in decisions about external reporting, what are the escalation criteria, etc.). See a sample from one institution attached.
2. Review the sample CARe procedure (for patient safety/risk staff) and algorithms and see how each of these steps might fit in with your current staff's workflow. Discuss with patient safety and risk staff how these elements can best be incorporated into what they are used to doing. Also review the best practices for CARe programs and best practices for interfacing with patients with this staff so they are aware of expectations.
3. Incorporate CARe into your case review process at every stage of adverse event review and particularly in your cause mapping, so that all levels of review focus on communication to the patient, root causes, patient safety improvements, and what is being done to resolve the situation.
4. Ensure that key staff in patient safety, risk, and other health care quality leaders are prepared to coach clinicians in conversations with patients about adverse events, and that the coaching is in line with CARe. You may need resources for "training the trainers".
5. Revise your DPH Serious Reportable Event letter templates (see sample letters for 7- and 30-days post-event) for and other patient-facing materials to ensure that they are complimentary to the CARe philosophy. Using your patient and family advisory council (PFAC) for the creation or revision of these materials can be helpful. Consider explanatory handouts regarding the CARe process for patients who have been harmed.

INSTITUTIONAL LOGISTICS

1. Assign a central internal pager number that clinicians can call at any time for "just-in-time" help with communication after an adverse event. This pager number can rotate among coaches and administrators on call, or remain with one lead coach with coverage as needed.
2. Create a page on your facility's internal website for staff to visit to learn more about CARe, find risk/safety departmental contact information, and find helpful tips on communicating with patients. It may be helpful to put this information near to where staff report events into an online patient safety reporting system.
3. Create a badge card and/or break-room posters with the pager number, patient safety phone number, and helpful tips on communicating with patients after adverse events.

INSURER AND HOSPITAL TEAM

1. Work with your insurer(s) to review their part in the CARe process, particularly with CARe insurer cases (cases in which you believe you did not meet the standard of care and that caused the patient significant harm). Include in your discussions:
   - How you will keep track of CARe cases that are handed over to them, and how you will update each other on the status of these cases (since time is of the essence)
   - How often the insurers will reach out to the patient and provider in CARe insurer cases
   - What your process should be when you receive a pre-litigation notice, particularly for those incidents that you had not heard about or investigated previously. Some suggested templates or guidelines are attached here.

2. If your facility has many physicians not employed by your institution and insured by outside entities, communicate to these insurers before launching CARe, so that if and when a case comes up, they are aware that CARe is used, and hopefully will be willing participants.

CARe CASE TRACKING

1. Pull cases from your adverse event database that meet CARe case "tracked event" criteria; these will be the cases on which you focus careful CARe attention, and will track using this tracking tool or a similar one you develop on your own. This tracking tool maps to the CARe algorithm steps, so that it is easier to ensure that CARe happens with every case, every time.
2. Determine how best to track data among your team. Consider having a central location where the tracking tool lives so it can be updated by all risk managers, or having a project manager complete the data after meetings about the cases.
3. Meet regularly with the event review team, including patient relations, to discuss any progress that has been made in the tracked cases, what still needs to be accomplished, and most importantly, how the patient and family are being kept in the loop throughout the review process.
4. Modify your reporting systems to help you obtain information from frontline users that you need for CARe that you might not already have access to in another way. Some suggested modifications can be found here.

INSTITUTIONAL EDUCATION

1. Review CARe presentation templates and revise as necessary for your institution. (Sample presentation can be found here.) Create a list of the different departments at your facility, and visit each one to explain the reasons for using CARe and what will change for them under this model. Revisit these departments at least annually to give updates, increase awareness, and ensure knowledge of resources.
2. Look for broad opportunities to promote the CARe program, including a story on your internal portal or in departmental publications.
3. Present as much as you can, in as many forums as you can, about CARe. Some good places to start are grand rounds, departmental meetings, hospital leadership, lunch and learns, and mortality and morbidity conferences. It is of great importance that clinicians understand the steps they need to take following an adverse event to have the best potential for resolution.
4. Add CARe information into your new physician/staff curriculum presentations.

SUSTAINING

1. Keep talking about CARe and continue giving presentations at your institution with updated data Incorporate data from CARe into your quality oversight and board meetings to help ensure continuity and accountability.
2. Review each CARe case that comes through using the CARe algorithms and keep track of the elements of CARe to make sure you are using the process consistently. You may want to track your total number of cases over time; it is also recommended that you use comparators such as other institutions using CARe in a similar setting.
3. Join a community where you can get support from others who have implemented CARe. Sites in Massachusetts that commit to joining the Betsy Lehman Center and using the process outlined here are welcome to join the quarterly Betsy Lehman Center CARe member meetings and discussion sessions. Non-member sites are welcome to sit-in on such meetings if requested ahead of time.

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