Fourth Annual CARe Forum

Massachusetts Medical Society
April 19, 2016

#ShareCARe2016

Forum Objectives

- Describe the necessary elements of an adverse event management process with a CARe program, and list some of the tools available to help start such a program.

- Describe the challenges insurers and attorneys face when effecting a resolution under a CARe program, and ways to overcome those challenges.

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MACRMI and CARe: What's New

Overview, accomplishments and new resources

Alan Woodward, M.D. and Melinda Van Niel, M.B.A.

What's Wrong with the Status Quo a/k/a Deny and Defend?

Patients - unfair, slow, inequitable, inefficient, isolating and no apology

Physicians - expensive, stressful, impacts health, modify practice and motivates defensive medicine

Healthcare system - compromises patient safety, workforce and access to care and drives defensive medicine, healthcare costs and number of underinsured

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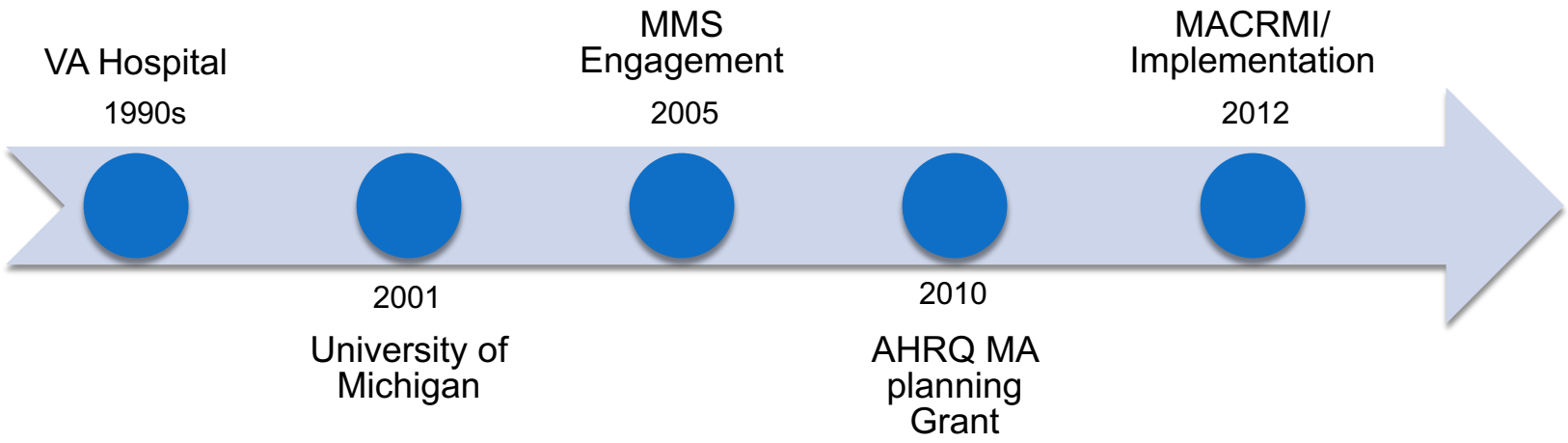
We need to do better

The full video from which the clip of Ms. Daly-Ullem was taken can be found here:

https://www.youtube.com/watch?v=7W5Ko5bPW_8

CRP History through 2012



Principles of CRP (DA&O)

- Compensate patients quickly and fairly when unreasonable medical care caused injury.
- If the care was reasonable or did not adversely affect the clinical outcome, support caregivers and the organization vigorously.
- Reduce patient injuries (and therefore claims) by learning through patients‘ experiences.

“Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions.” Boothman, et al; Frontiers of Health Service Management 28:3; study at the University of Michigan Health System

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AHRQ Planning Grant - Massachusetts

- Identified 12 barriers to implementation and strategies to overcome each
- General recognition system needs to change
- No better option for Reform

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Roadmap: Overcoming Barriers

- Enabling Legislation - to create a supportive environment for broad adoption
- Education - programs for all involved parties
- Leadership - from all key constituencies
- Best Practices - support consistency
- Collaborative Working Groups - key issues
- Data Collection and Dissemination

MMS/MBA/ MATA

Alliance

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Liability Reform Provisions of Ch. 224

- Six Month Pre-Litigation Resolution Period*
- Sharing all Pertinent Medical Records*
- Apology Protection - unless contradictory*
- Full Disclosure - significant complication*
- Pre-judgment Interest Reduction - T+2
- Charitable Immunity Cap Increase - 100k

Signed into law as part of Chapter 224 - Payment Reform Legislation; Effective November 5, 2012

*** MMS, MATA & MBA Consensus**

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MITSS
Medically Induced Trauma Support Services

CRICO RMF
Protecting providers. Promoting safety.

COVERYS

MBA

Massachusetts Medical Society
Every physician matters, each patient counts.

Beth Israel Deaconess Medical Center

Baystate Health

MHA Massachusetts Hospital Association
The leading voice for hospitals.

Board of Registration in Medicine

Massachusetts Coalition for the Prevention of Medical Errors

Atrius Health

STURDY MEMORIAL HOSPITAL

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"**CARe**" (Communication, Apology, and Resolution) is MACRMI's preferred way to reference the process.

What is Communication, Apology, and Resolution (CARe)?

- **Communicate** with patients and families when unanticipated adverse outcomes occur.
- **Investigate and explain** what happened.
- Implement systems to **avoid recurrences** of incidents and improve patient safety.
- Where appropriate, **apologize and offer** fair financial compensation without the patient having to file a lawsuit.

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Why CARe? (Transformational)

Reactive	⇨	Proactive
Adversarial	⇨	Advocacy
Culture of secrecy	⇨	Full disclosure / transparency
Denial	⇨	Apology (healing)
Individual blame	⇨	System improvement
Patient/MD isolation	⇨	Supportive assistance
Fear	⇨	Trust
Defensive medicine	⇨	Evidence-based medicine

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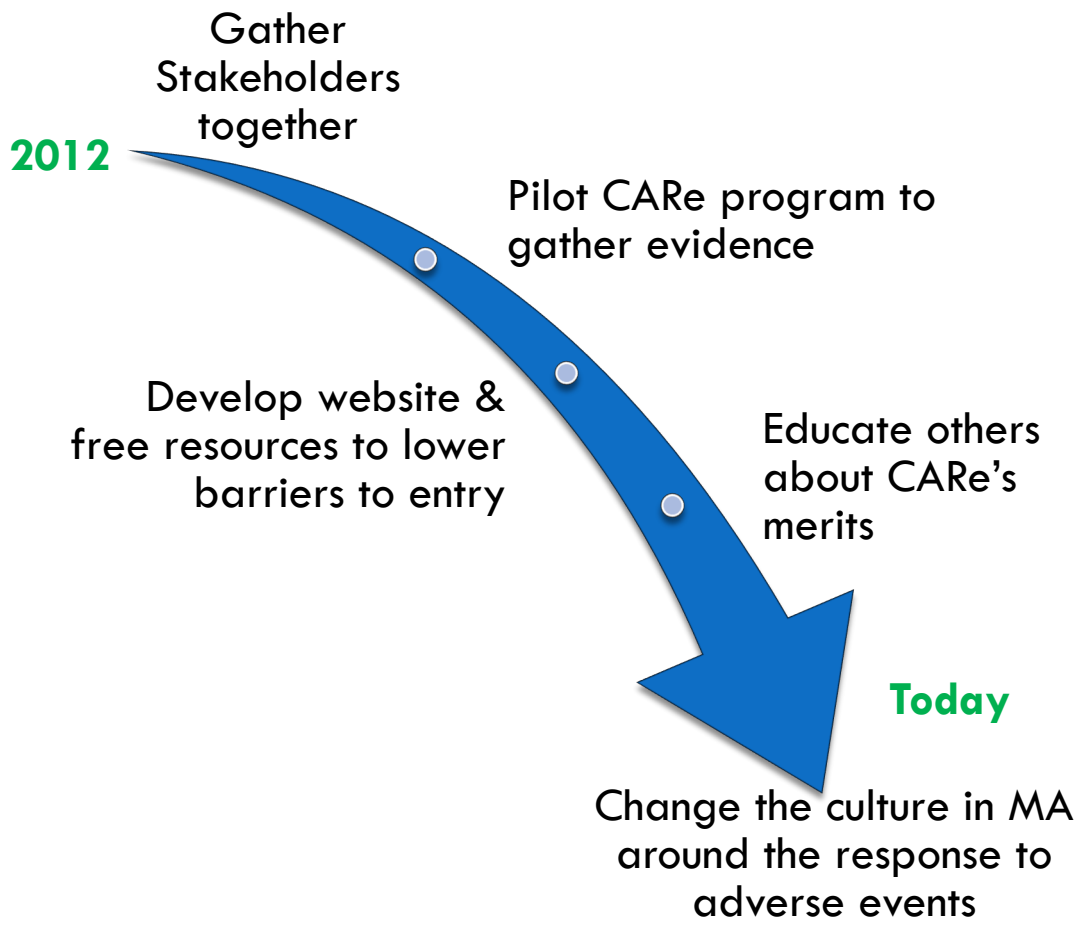
Initial Implementation

- Released Roadmap / Media Campaign
- Secured local funding
- Established Pilot Programs in varied sites
- Developed comprehensive resources, educational materials and algorithms
- Launched Website
- Hosted Annual Forums
- Changed / clarified reporting requirements

MACRMI's Journey



Lessons Learned – 3 Years Later

- Consistency
  - Rigor in the CARe process for **all** adverse events is essential to the success of the program – *including* those events which were unavoidable complications.
- Leadership
  - Leadership must be on board, and continuously advocate, especially when it's the hard thing to do
- Teamwork
  - CARe works best when risk management and patient relations communicate and work together with insurer

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Lessons Learned – 3 Years Later

- Support
  - Providers (clinician peer support; education/information about CARe process)
  - Patients (Patient Relations; Education; social work; MITSS; Representation)
- Reinforcement
  - Re-education and reaffirming the CARe process throughout the institution helps to move toward a cultural change

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CARe – Not a Revolutionary Idea

Accomplishments since 2015 Forum

- Data collection for pilot projects completed
  - 3-year implementation study
  - 1-year provider opinion study
- Continued educational presentations
  - Several facilities beginning work on implementation or with high level of interest
- Developed multiple new resources
- Updated Website
  - Video Library
  - Speakers list
- Monthly “Open Office Hours” 4th Monday, 12-1pm
- Contributed to CRP national dissemination
  - AHRQ Toolkit/ CAI Education and Leadership

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Resources developed since May 2015

- CARe Timeline with Integrated Resources
- CARe Suggested Attorney List
- Tracking Spreadsheet Tool
- Introductory Powerpoint Presentation
- Guide to Starting a Statewide CARe Collaborative

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CARe Timeline

Program Setup

Preparation

Ensure that the safety culture at your institution supports a CARe program

Set up resources

Educate providers

- Readiness Checklist
- Implementation Team

- Implementation Guide
- Implementation Team

- Best Practices for CARe Programs
- Implementation Team

24-48 hours after event

(algorithm steps 1, 2)

1

Patient Safety Alerted

Support services for providers and patients launched

Discussion with patient regarding error and known facts

- Sample Communication Policy
- Risk Managers/All Staff

- Best Practices for Interfacing with Patients
- Patient Relations

- Unexpected Outcome Sheet
- Patients

2-4 weeks after event

(algorithm step 3)

2

Internal investigation takes place

Patient Safety and Patient Relations maintain contact with providers and patients respectively

- DPH SRE Letter Templates
- Risk Managers

1-3 months after event

(algorithm steps 4, 5)

3

Determination of CARe criteria fit

Providers, Chiefs, and Directors consulted

Team huddle; designee conducts Initial CARe Communication with the patient; connects them to Insurer for record release

- CARe Algorithms
- Risk Managers

- Insurer Referral Document (to be finished)
- Patient Relations/Risk Managers

2-5 months after event

(algorithm steps 6, 7, 8, 9)

4

Insurer reviews case and develops offer parameters

Provider/System Allocation by Insurer

Insurer invites patient to CARe Initial Meeting; recommends that counsel also attend

Corrective actions implemented at site

- Best Practices for Patient Representation
- Risk Managers/Insurers

- Suggested Insurer Contact Timeline
- Insurers

3-6 months+ after event

(algorithm steps 10, 11)

5

Initial meeting with insurers, providers, patient safety staff, patient, counsel, and other parties

Additional resolution meetings occur as necessary

Financial offer to patient made and accepted or rejected (settlement may be negotiated)

- Guidelines for Initial CARe meeting
- Risk Managers/Insurers

- Best Practices for Attorneys Representing Patients
- Attorneys

- Best Practices for Attorneys Representing Providers
- Attorneys

● Resources ● Audience

CARe Suggested Attorney List

- Patients are encouraged to have attorneys during resolution conversations
- All stakeholders prefer experienced attorneys who understand the CARe process
- Attorneys on the list have attended/viewed an Attorney Forum and signed a statement that they will abide by CARe Best Practices

Suggested Attorney List

MACRMI Suggested Attorney List

If you are a patient going through the CARe process and are looking for an attorney, the Massachusetts Alliance for Communication and Resolution following Medical Injury suggests those in the list below. These attorneys have committed to follow the Best Practices for Attorneys Representing Patients in the CARe Process, and have attended an educational session about the CARe process.

Please note that you have the right to have any attorney of your choice, even those not on this list, as your representative in the CARe Process.

Robert H. Astor, Esquire
The Law Offices of Robert H. Astor
Offices in Springfield and Northampton, MA
https://attorneyastor.com/
Phone: 413-781-1144 or 413-584-4348

C. William Barrett, Esquire
Esdaile, Barrett, Jacobs & Mone, LLP
75 Federal Street, Boston, MA
http://www.ebjmlaw.net/
Phone: (617) 482-0333

Jeffrey N. Catalano, Esquire
Todd & Weld, LLP
1 Federal Street, Boston, MA
http://www.toddweld.com/
jcatalano@toddweld.com

Charlotte E. Glinka, Esquire
Keches Law Group, PC
2 Granite Ave, Ste. 400, Milton, MA
http://kecheslaw.com/
Phone: (508) 822-2000

Susan Sachs, Esquire
Susan Sachs, Attorney at Law
75 Market Place, Springfield, MA
http://www.sachs-law.net/
Phone: (413) 732-0035

Kimberly E. Winter, Esquire
White, Freeman & Winter
30 Colpitts Rd., Weston, MA
http://whitefwinter.com/
Phone: (781) 893-4700

CARe Tracking Tool

Each case that meets the CARe threshold is tracked individually

Grays out content once closed

*File ID	*Risk Manager or Patient Relations Staff Responsible	*Patient Name	*Event Date	*Description of Event	*Was This Event Communicated to Patient/Family (Disclosure Conversation)?	Current Status	Preventable? (Yes/No/Unknown)	Bills held/waived/service recovery	Follow-up Attempted with pt/fam?	Details	After 1st attempt, need further follow-up?	2nd Follow-up attempted?	Need further follow-up?	CARe Insurer case? (Yes/No)
1000	CW	Frog, Kermit	1/1/2016	Fall with fracture	Yes	Follow-up with pt/fam	Yes	Bills held	Yes	Left a message with patient to let them know that we would like to refer this to our insurer 1/3/16	Yes			Yes
1001	CW	Seashore, Sally	8/1/2015	Specimen misplaced	Yes	Closed	Yes	Service recovery	Yes	Left message 10/1/15. Talked to patient 10/5/15. Waived procedure fees, paid parking. No sig harm. Patient	Yes	Yes	No	Yes
1002	JK	Smith, John	10/1/2015	Delay in diagnosis of ovarian cancer	Unknown	Under review	Unknown		No	Waiting to contact patient until review is complete				

Interactive cells highlight important areas to follow up on

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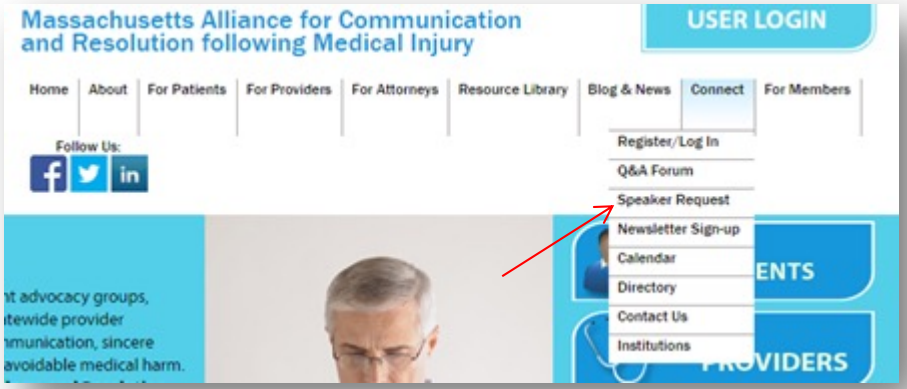
Educational Powerpoint

- Want to talk about CARe* at an M&M? A Departmental Meeting? A Board Meeting?

  Don’t reinvent the wheel!

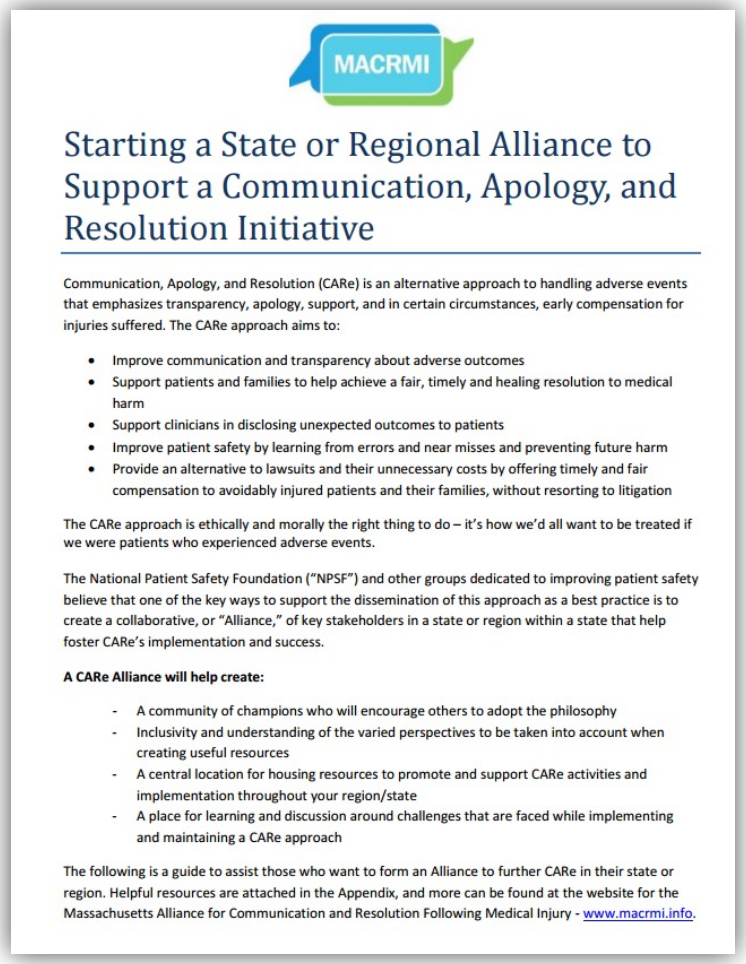
Communication, Apology, and Resolution (CARe): Approaching Adverse Events with Empathy

Name, Credentials, etc.



*We are happy to help support you by presenting with you, or for you! (See our speaker’s list online for more information).

Guide to Starting a Statewide Collaborative



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Starting a State or Regional Alliance to Support a Communication, Apology, and Resolution Initiative

Communication, Apology, and Resolution (CARe) is an alternative approach to handling adverse events that emphasizes transparency, apology, support, and in certain circumstances, early compensation for injuries suffered. The CARe approach aims to:

- Improve communication and transparency about adverse outcomes
- Support patients and families to help achieve a fair, timely and healing resolution to medical harm
- Support clinicians in disclosing unexpected outcomes to patients
- Improve patient safety by learning from errors and near misses and preventing future harm
- Provide an alternative to lawsuits and their unnecessary costs by offering timely and fair compensation to avoidably injured patients and their families, without resorting to litigation

The CARe approach is ethically and morally the right thing to do – it's how we'd all want to be treated if we were patients who experienced adverse events.

The National Patient Safety Foundation ("NPSF") and other groups dedicated to improving patient safety believe that one of the key ways to support the dissemination of this approach as a best practice is to create a collaborative, or "Alliance," of key stakeholders in a state or region within a state that help foster CARe's implementation and success.

A CARe Alliance will help create:

- A community of champions who will encourage others to adopt the philosophy
- Inclusivity and understanding of the varied perspectives to be taken into account when creating useful resources
- A central location for housing resources to promote and support CARe activities and implementation throughout your region/state
- A place for learning and discussion around challenges that are faced while implementing and maintaining a CARe approach

The following is a guide to assist those who want to form an Alliance to further CARe in their state or region. Helpful resources are attached in the Appendix, and more can be found at the website for the Massachusetts Alliance for Communication and Resolution Following Medical Injury - www.macrmi.info.

- Resource designed for other states/regions who want to move toward CARe
- Having a group of committed stakeholders working together reduces barriers to spread/adoption

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Coming soon…

- Guidelines for Resolution Conversations
  - Community voiced a need for suggested language when referring to an Insurer
  - Help guiding consistent approach for all those that meet CARe Criteria, regardless of the patient's disposition
- Letter-Writing Guides
  - Assistance with language for letters to assert a medical error or to respond to a letter asserting an error
- Participating Institution/Group List for Patients
  - An easy-to-find tab where all participants and Patient Relation contact information is posted centrally

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All Resources Available on our Website: **www.macrmi.info**

HORIZON INTERACTIVE AWARDS BRONZE WINNER

MARCOM AWARDS

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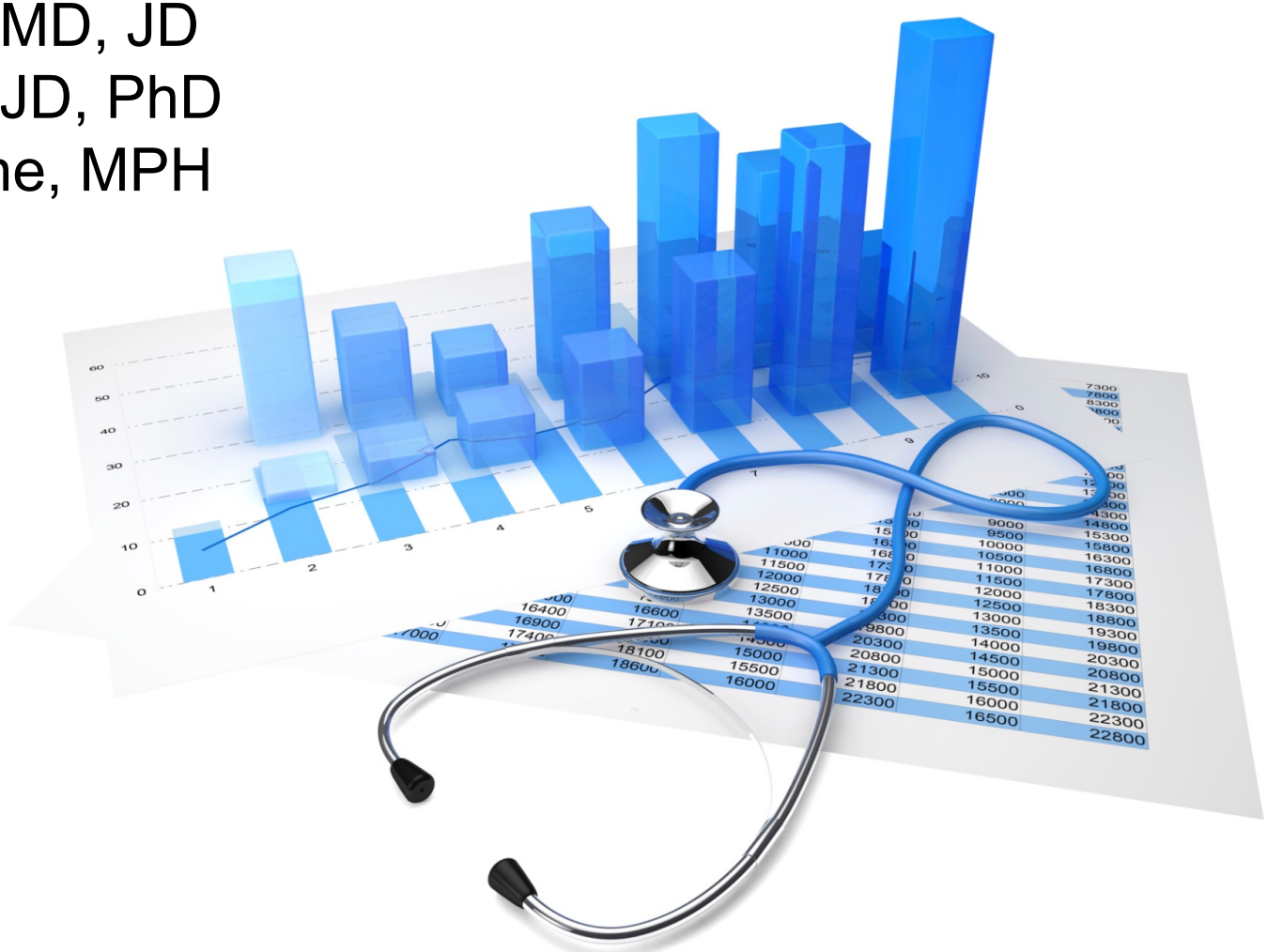
CARe Interim Data Snapshot

April 19, 2016

Allen Kachalia, MD, JD
Michelle Mello, JD, PhD
Stephanie Roche, MPH



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If you would like the data slides presented at the Forum, please email your request to: Stephanie Roche

sroche2@bidmc.harvard.edu

Insurer Panel

The panel participants were:

Allain Collins, Esq. – Claims Manager, CRICO RMF

Stephanie Sheps, Esq. – Director of Claims, Coverys

Robert Astor, Esq. – Plaintiff's Attorney at his own practice in Springfield and Northampton

Kevin Giordano, Esq. – Defense Attorney at Keyes & Donnellan PC

Theresa Ott, RN – Claims Manager, Baystate Health

Provider Panel

The panel participants were:

- Dr. Brook Longmaid **– Chief of Radiology, and President of the Medical Staff, BID- Milton**
- Dr. Daniel Grow **- Chair, Department of Obstetrics-Gynecology, Baystate Medical Center**
- Dr. Ronald Gross **- Chief, Division of Trauma, Acute Care Surgery & Surgical Critical Care Baystate Medical Center**
- Dr. Kevin Moriarty – **Chief, Pediatric Surgery Division**

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Be Relentlessly Stubborn and Stay the Course

Richard C. Boothman
Executive Director for Clinical Safety
Chief Risk Officer
University of Michigan Health System

Massachusetts Alliance for Communication and Resolution following Medical Injury
April 19, 2016

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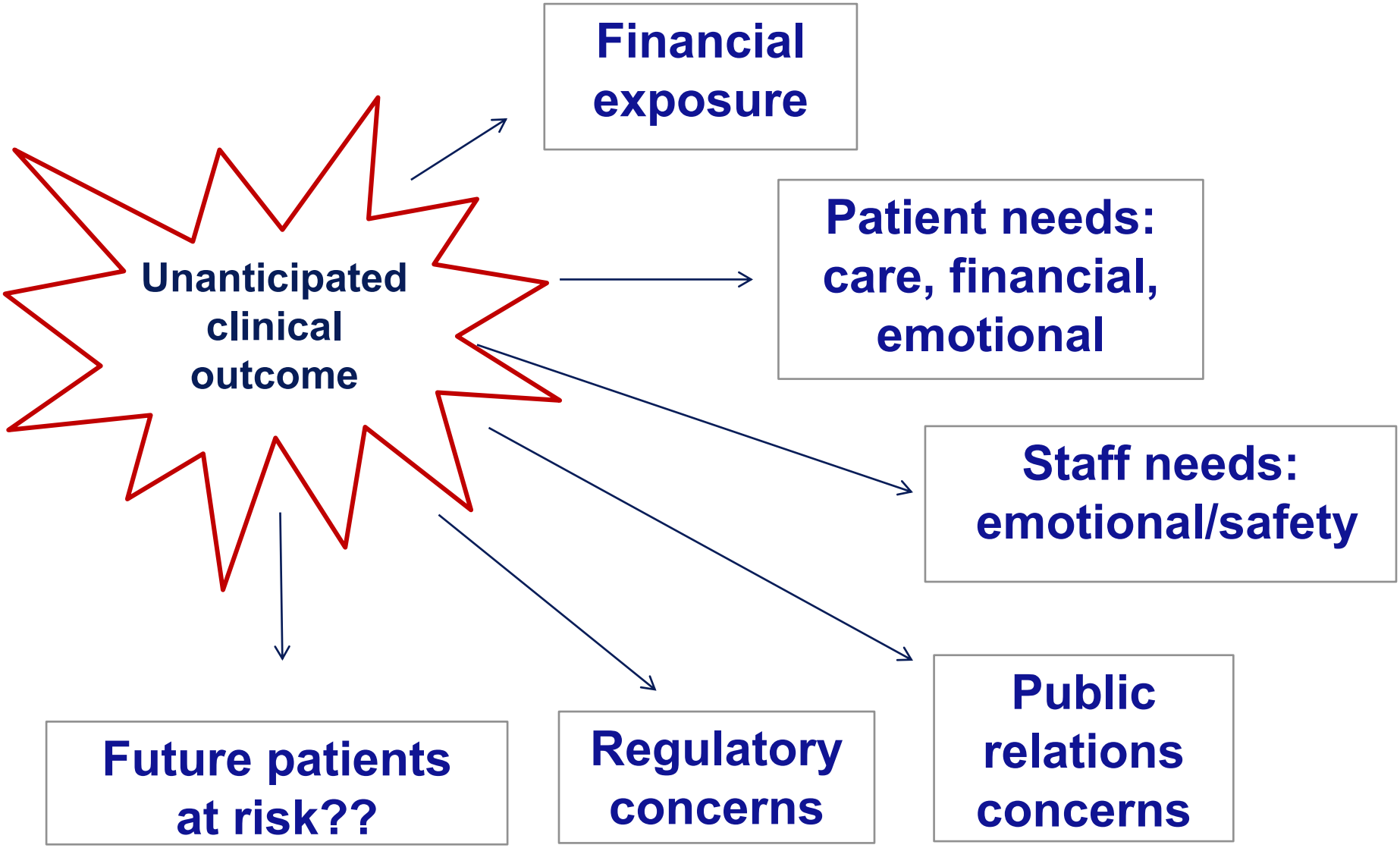
Never forget WHY

Unexpected harm triggers multiple concerns



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Priorities have been backward

When an adverse event occurs, we are changed

We now know that patients can be unintentionally harmed in the context of that care

The best risk management is not to hurt our patients in avoidable or preventable ways

The second-best is not to do it again

When an adverse event occurs, the focus should be on the patient we have not hurt *yet!!*

The impact (and real cost) of Deny and Defend

Unanticipated clinical outcome

→

Financial exposure

Patient needs: care, financial, emotional

Staff needs: emotional/safety

Regulatory concerns

Public relations concerns

Future patients at risk??

The Michigan Model difference

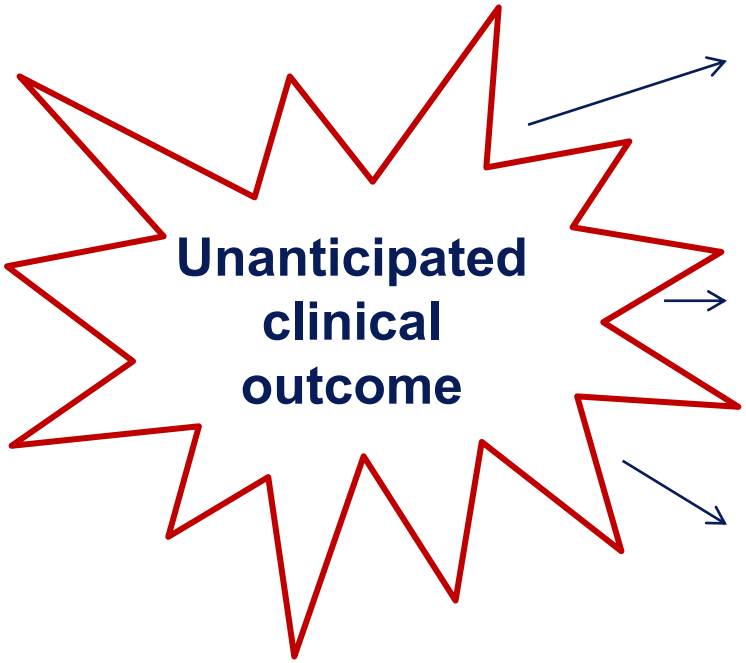
Short-Term: Bedrock Claims Principles
Long-Term: Focus on Improvement

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

We will support our staff when the healthcare involved was reasonable

We will reduce patient injuries (and claims) by learning from our patients' experiences

The Michigan Model difference



Patient needs: care, financial, emotional

Staff needs: emotional/safety

Future patients at risk??

Prioritize these, then pay attention to secondary concerns

Regulatory concerns

Financial exposure

Public relations concerns

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Why has the Michigan Model survived?

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It serves patients' and families' needs

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How did Michigan's approach affect you in your way of thinking about the whole thing?

Well, to be honest after that night I left there like I was on a mountain top. I felt like I had finally been heard, they listened. I mean I had all these very important people in that room listening to me, they were there because of my story ***and if that had been the end of the legal pursuit that would have been fine with me***. I was I was perfectly satisfied after that night. I felt like I finally had spoken up for myself.

Jennifer 2007

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One plaintiff's lawyer's experience

"Instead of adversarial, it was conversational. It was instead of trying to figure out what claims and defenses needed to be, I found myself trying to figure out some higher calling, what's the right thing to do here? What's the best thing to do here? ***My role changed from advocate to warrior to counselor is the best way that I can describe it.*** We are attorneys *and* counselors and the counselor part got emphasized, in fact, became the dominant, the ascendant part just as soon as it became clear the University Hospital was gonna take a different approach to this case."

Tom Blaske 2007

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Plaintiffs' Bar's Response (51 surveyed Jan, 2006)

- 100% rated UMHS "the best" and "among the best" health systems for transparency
- 90% recognized a change since 2001
- 81% said they changed their approach to meet our change
- 81% said their costs were less
- 71% settled cases for less than had they litigated
- 86% said transparency allowed them to make better decisions about claims to pursue
- 57% admitted that they turned cases down they otherwise would have pursued

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It serves our caregivers' needs

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Dear Mr. Boothman,

Wanted to let you know there is a great article in today's NY Times that paints your work here at Michigan in very favorable light. Also, I thought I'd mention that Michigan's medical error policy was a big part of my choosing to come to residency here.

I'm sure I'm not alone. Keep up the good work!

With deep appreciation,

Melissa _____

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Hi Rick,

I just returned from a week long leadership course at the Harvard School of Public Health. One of the presentations was regarding the legal and ethical issue of medical error. He highlighted your medical error disclosure program as the exemplary model of how to reduce the litigations. There were some skeptics in the crowd, but I shared that this program has really facilitated the improvement of provider-patient relationship at Michigan, which ultimately is the what we want to preserve as the driver of improving quality and safety.

I felt so proud to hear of your work and just wanted to drop you a note!

Thanks!!

John _____, MD, PhD

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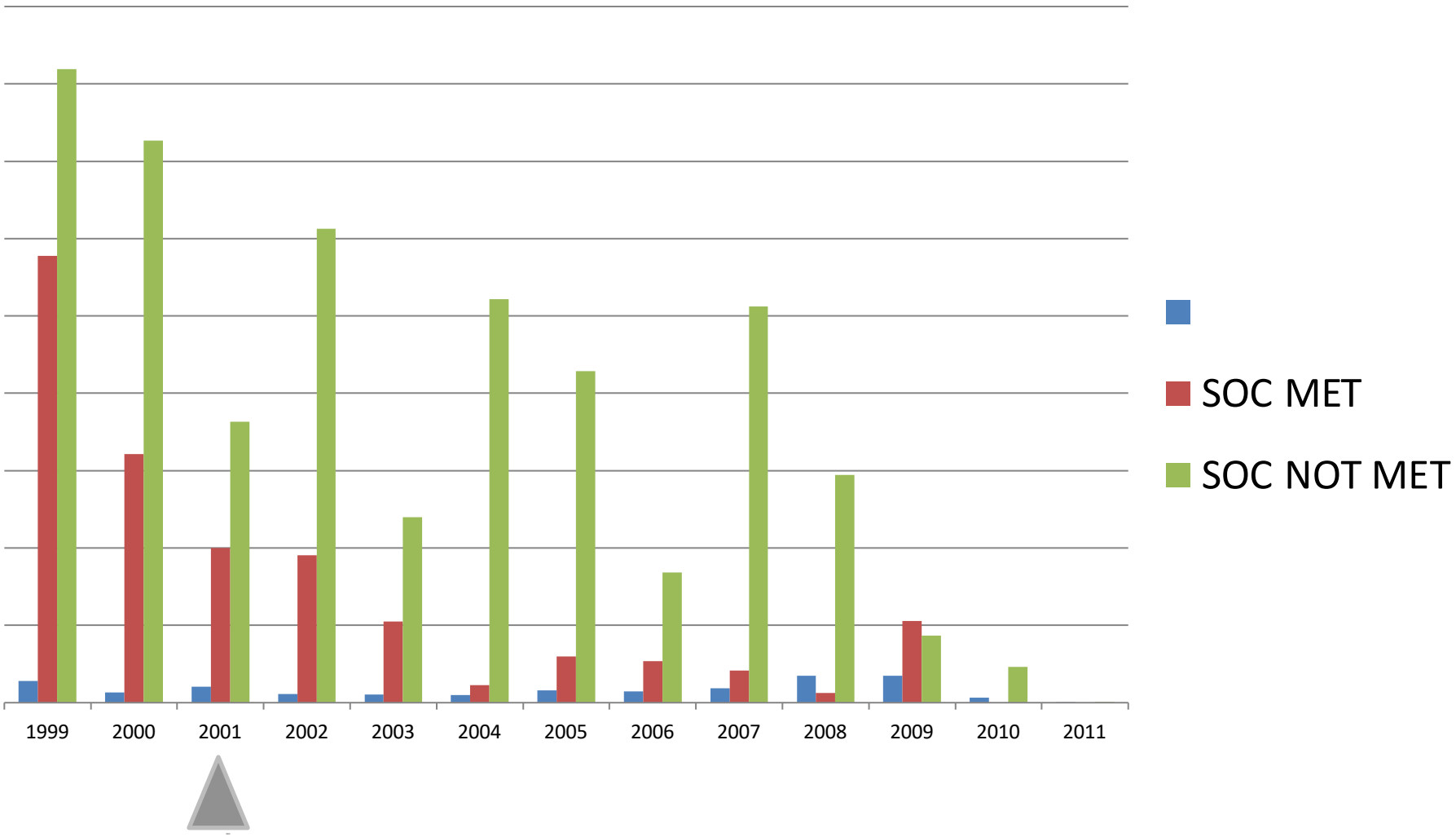
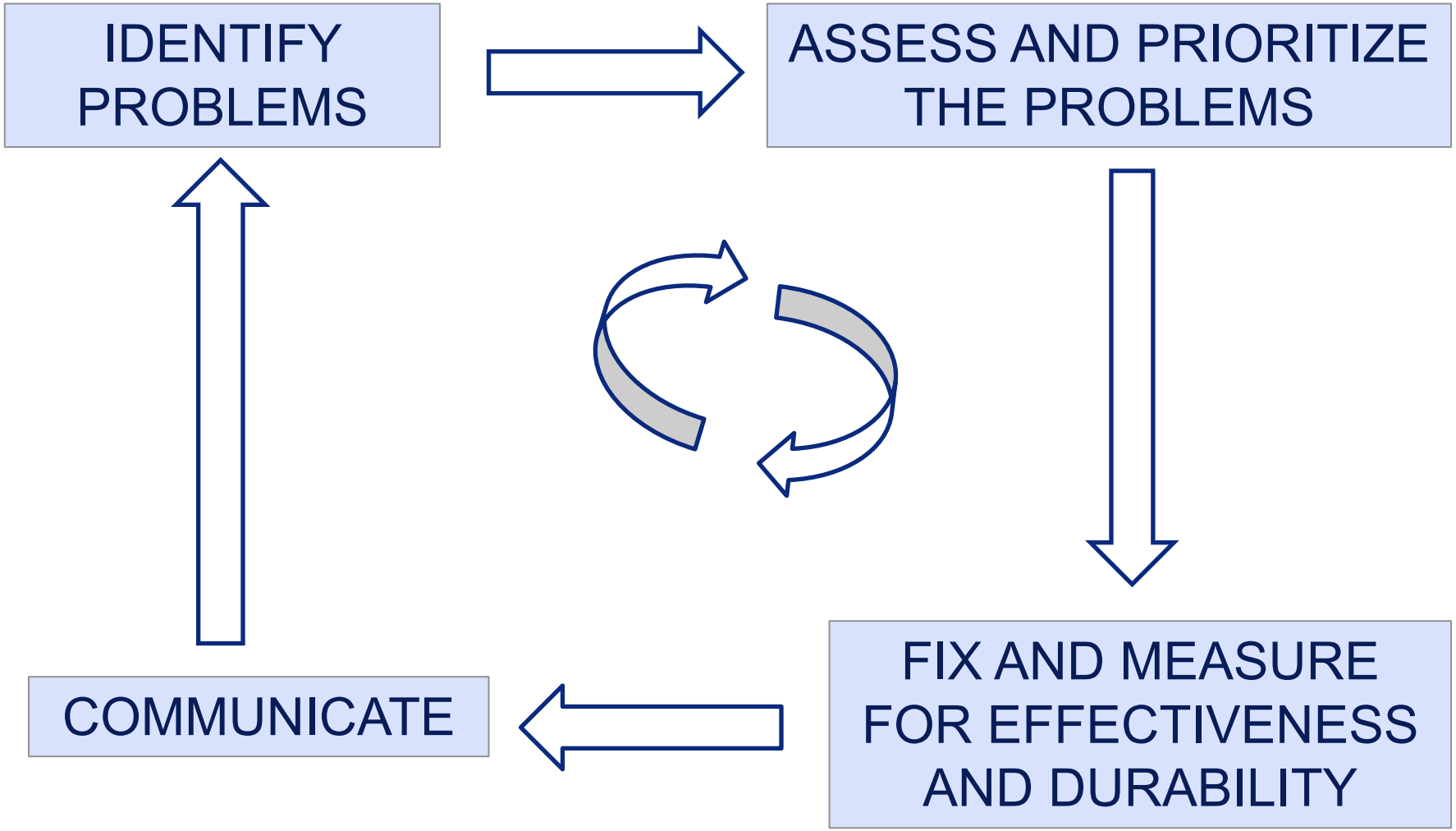
Most importantly, it serves our organization's core mission

UMHS RISK MANAGEMENT CLAIMS BY INCIDENT DATE Money Paid per UMHS's Standard of Care Assessment



Functional Flow for Clinical Improvement



The role of compensation in accountability

Apology without compensation is a sham. (T)he essential components of meaningful apology are taking responsibility, showing remorse and making restitution. The last is curiously absent from many otherwise excellent apologies. But the most expertly delivered, heartfelt apology is hollow if nothing is done to try to make the patient whole. This has to change.

The challenge isn't finding the money, it is convincing people to make the change and developing fair and efficient mechanisms to make it happen. There will be resistance from all quarters: the lawyers, the risk managers, the accountants, and physician skeptics. Leaders must persevere.

Leape, Lucian L.
Apology for Errors: Whose Responsibility?
Frontiers of Health Service Management,
Vol 28, No. 3, 10-11 (2012)

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"Why in hell would we do THIS? We're already paying out a king's ransom! You must be insane."

Executive for a captive insurance program
reacting to the Michigan Model
2009

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Meaningful improvement will only occur if you normalize honesty and react with transparency

Why would anyone NOT do this?

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Why do we do this?

Because “it” is the single best way to build ownership and accountability for the quality and safety of the care we provide to the people who place their lives in our hands

Because it is the best way to serve the people who dedicate their lives to delivering that care

And consequently, it’s the best way to serve the organizations whose very reason for being is to deliver optimal health care

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“IT” is not “Apologies Save Money”
“IT” is not “Doctors Say Sorry”
“IT” is not “Sorry Works!”
“IT” is not PollyAnna

“IT” is a thoughtful, principle-based, and integrated response to unanticipated clinical events that best serves our core health care mission in both, the short-term and long-term

Join Us

- We invite you to make the commitment to use the CARe program for adverse events
- What it means to be a MACRMI member:
  - Use the CARe algorithms and best practices
  - Track your cases to ensure consistency
  - Attend quarterly meetings
  - Help spread the word

Join Us

- Want to talk more?
  - All MACRMI Members have the logo on their name tags – feel free to talk any of them!
- Ready to Commit?
  - Go to our website and click here to get the process started.

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