5th Annual CARe Forum

Massachusetts Medical Society
April 13, 2017

#MACRMI5

Forum Objectives – Session 1

- Understand the history of the CARe approach and its basic principles
- Describe the necessary elements of an adverse event management process in a facility with a CARe program, and list some of the tools available to help facilities start such a program.

CARe & MACRMI: The History, Background, and Principles

Alan C. Woodward, MD

Co-Chair, Massachusetts Alliance for Communication and Resolution following Medical Injury

Why do patients sue?

- "Studies show that the most important factor in people's decisions to file lawsuits is not negligence, but **ineffective communication** between patients and providers."

- "Malpractice suits often result when an unexpected adverse outcome is met with a **lack of empathy** from physicians and a **perceived or actual withholding of information**."

Clinton & Obama, NEJM 2006
Vincent C, Lancet 1993

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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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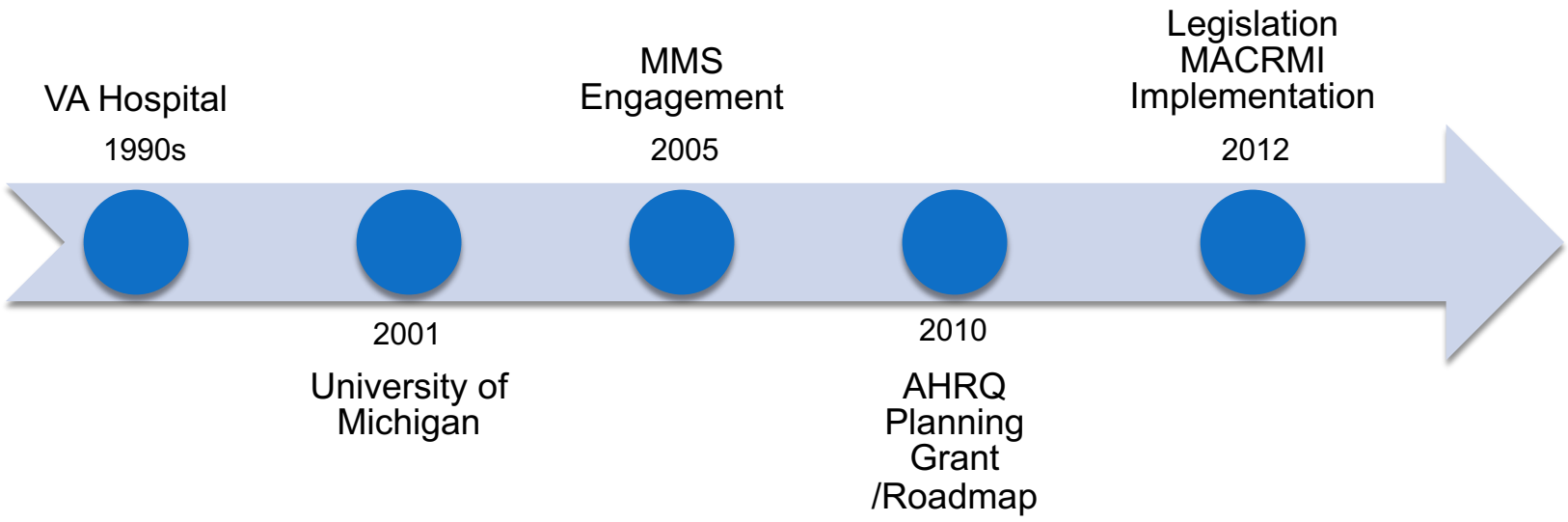
DA&O / CARe History through 2012



Principles of CARe

- 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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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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Evidence: University of Michigan

- Started in 2001 (262 claims and > 300 open cases)
- By 2007, only 73 new claims and < 80 open cases
- Average case resolution time down from 20 months to 8 months
- Transaction expenses reduced $48k to < $20k/case
- Stopped buying reinsurance
- Reduced reserves $72M to <$20M, funding patient safety initiatives
- Court cases reduced more than 90% (1-2/yr)
- Provide unlimited coverage with lower premiums
- Incident reporting - increased many fold
- Culture change – fear reduced – no longer teach DM

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AHRQ Planning Grant - Massachusetts

- 1 Yr - 300K AHRQ Planning Grant - MMS / BIDMC
- Key informant interview study of 27 knowledgeable individuals from all leading stakeholder constituencies in Massachusetts
- Twelve significant barriers were identified along with multiple strategies to overcome each one
- Strategies for each barrier were then evaluated and prioritized to develop our Roadmap
- **CARe is the best of all options for liability reform, the right thing to do and broad support exists for change**

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AHRQ Planning Grant - Massachusetts

- Top five significant barriers identified
  1. Charitable immunity law
  2. Physician discomfort with disclosure & apology
  3. Attorneys' interest in maintaining status quo
  4. Coordination across insurers
  5. NPDB or state reporting requirements

- Roadmap to overcome barriers
  - Enabling legislation — MMS, MATA, MBA
  - Educational programs — MACRMI
  - Leadership — MACRMI
  - Best Practices/Resources — MACRMI
  - Collaborative working groups — MACRMI
  - Data collection and dissemination — MACRMI

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

STURDY MEMORIAL HOSPITAL

Atrius Health

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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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Initial MACRMI Efforts

- Secured local funding
- Established Pilot Programs
- Launched Website
- Developed multiple resources
- Hosted Annual Forums
- Clarified reporting requirements

Funding for Implementation

- AHRQ - $3M / 3Yr Demonstration Grant
  - $50M in ACA - no appropriation

- Local sources - all contributed
  - CRICO and BHIC for pilots
  - BCBS, HPHC, TAHP
  - Coverys, MMS & Reliant

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The Massachusetts Pilot Sites

Site	#Beds	Location	Teaching (Y/N)
Beth Israel Deaconess Medical Center	642	Inner City	Y
BID-Milton	88	Community	N
BID-Needham	58	Community	N
Baystate Medical Center	716	Inner City	Y
Baystate Franklin Medical Center	93	Community	N
Baystate Mary Lane Hospital	31	Community	N
*Atrius Health**	*n/a*	*Ambulatory*	*N*
*Sturdy Memorial**	*128*	*Community*	*N*

**More recent programs not included in study*

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Website: **www.macrmi.info**

HORIZON INTERACTIVE AWARDS BRONZE WINNER

MARCOM AWARDS

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MACRMI Resources

- CARe Best Practices for institutions, patient interaction and patient representation
- Patient Brochure and Information Sheet
- Site Readiness Checklist
- Sample policies / procedures for implementing CARe
- FAQs for Patients, Providers and Attorneys
- Slide decks for teaching the concepts to clinicians - ID Badge instructions
- CARe Algorithms (see list in HO)

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State and NPDB Reporting

Changed state reporting statute

NPDB-HRSA-HHS

Clarification that there must be a written demand for payment and that payment must be made on behalf of MD

Added FAQs for CRPs in the New Guidelines

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Recent Efforts

- Continued work to disseminate the CARe model in MA, regionally and nationally
- Completed pilot data collection on 1000 cases to study outcomes and implementation
- Collected 1 Yr of data on provider perceptions of the CARe process
- Developed additional resources
- Facilitated CARe Educational Forums for Attorneys and initiated list

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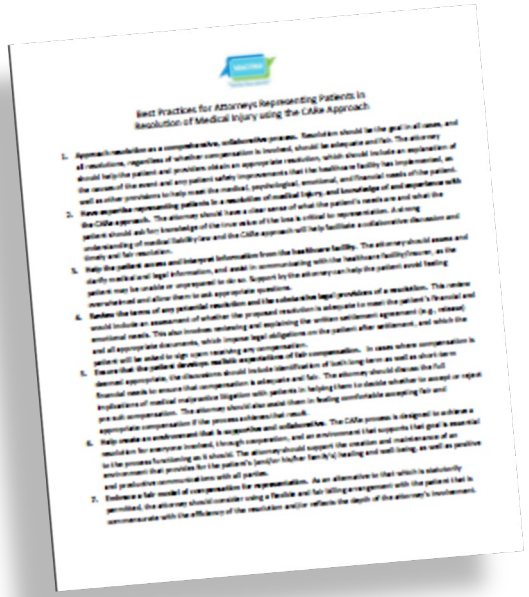
Attorney Best Practices-Seminars-List

- MBA and MACRMI jointly developed Guidelines for Attorneys representing patients or providers in the CARe process
- Jointly sponsored seminars to educate attorneys about CARe
- Suggested list


Best Practices for Attorneys Representing Patients in Resolution of Medical Injury using the CARe Approach

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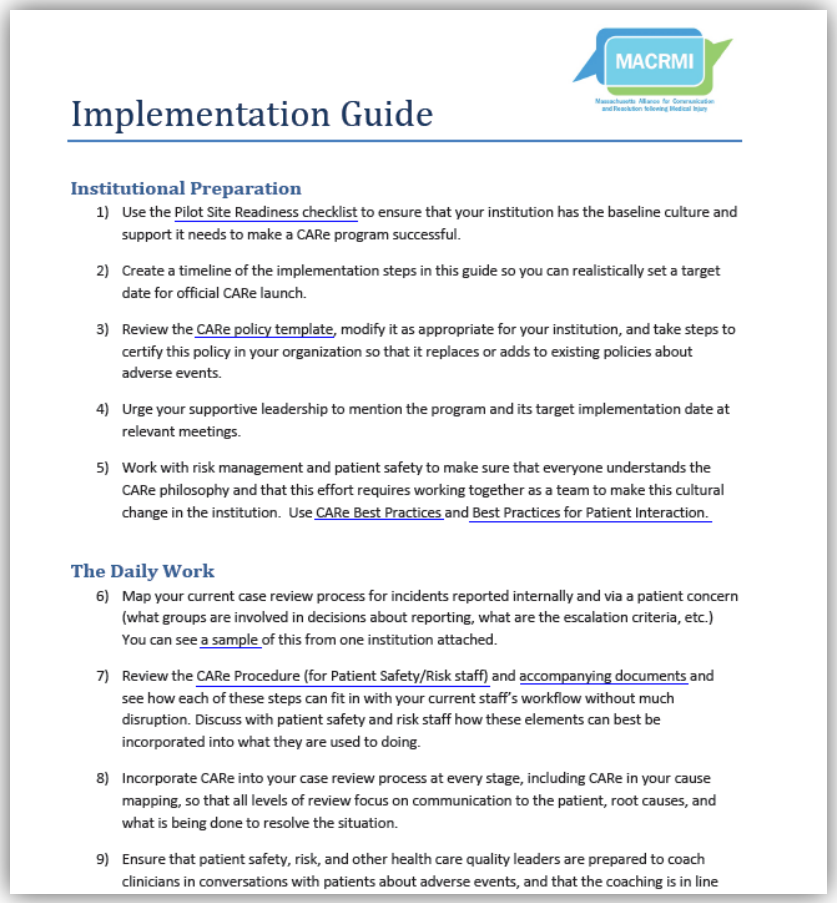
CARe Implementation Guide

- Designed for institutions interested in implementing the CARe Program
- Aided by personal assistance from our implementation team
- Lays out timeline of important tasks, and each step links to relevant MACRMI resources



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Implementation Guide

Institutional Preparation

1) Use the Pilot Site Readiness checklist to ensure that your institution has the baseline culture and support it needs to make a CARe program successful.
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. Use CARe Best Practices and Best Practices for Patient Interaction.

The Daily Work

6) Map your current case review process for incidents reported internally and via a patient concern (what groups are involved in decisions about reporting, what are the escalation criteria, etc.) You can see a sample of this from one institution attached.
7) Review the CARe Procedure (for Patient Safety/Risk staff) and accompanying documents and see how each of these steps can fit in with your current staff's workflow without much disruption. Discuss with patient safety and risk staff how these elements can best be incorporated into what they are used to doing.
8) Incorporate CARe into your case review process at every stage, including CARe in your cause mapping, so that all levels of review focus on communication to the patient, root causes, and what is being done to resolve the situation.
9) Ensure that 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

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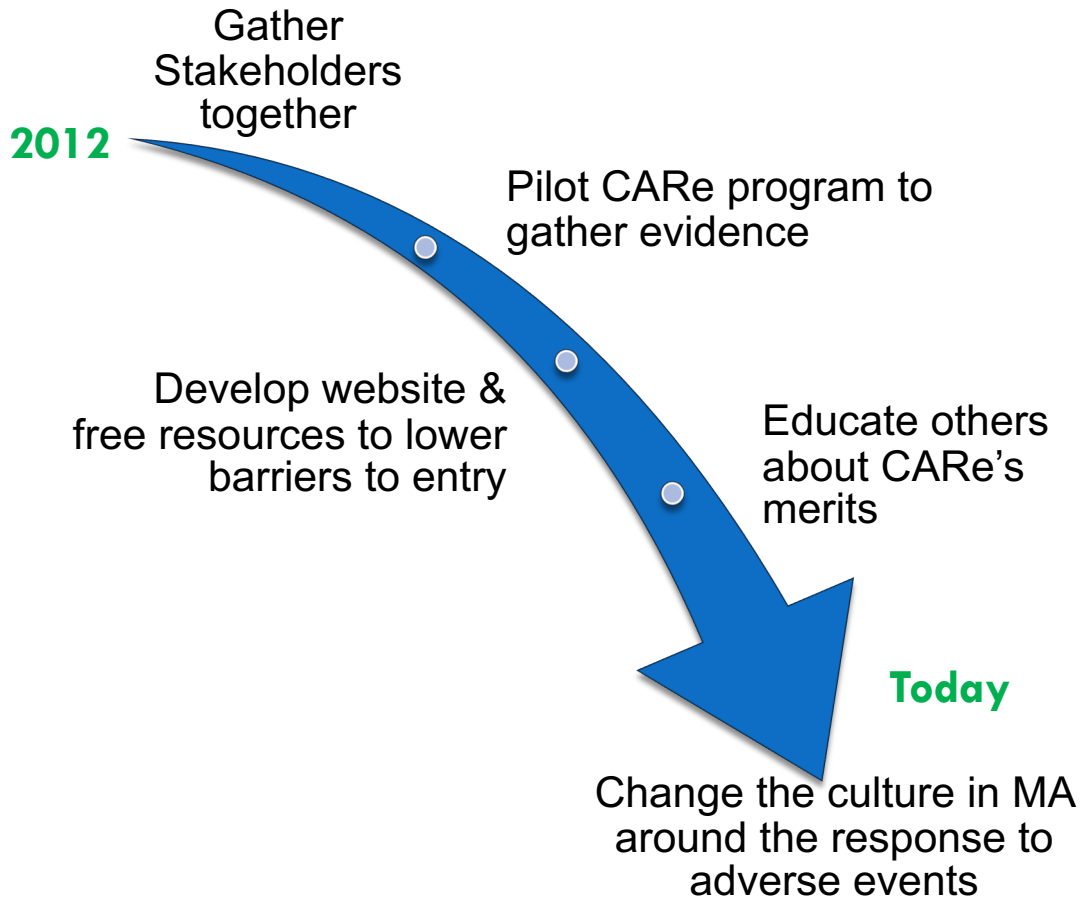
MACRMI's Journey



Where we're going…

-Developing Best Practices for Insurers

-Adding additional CARe sites in MA

-Continuing regional and national dissemination efforts (CAI)

-Completing data analysis for publication

-Maintaining MACRMI and its resources

Conclusion - Multiple Benefits

Right and Smart thing to do

- For Patients (you)
- For Patient Safety
- For Providers
- For Hospitals / ACOs
- For Healthcare Access and Affordability

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CARe Implementation: How it works, and how to get a program up and running at your institution

Evan Benjamin, MD, MS

SVP, Chief Quality & Population Health Officer

Baystate Health Inc.

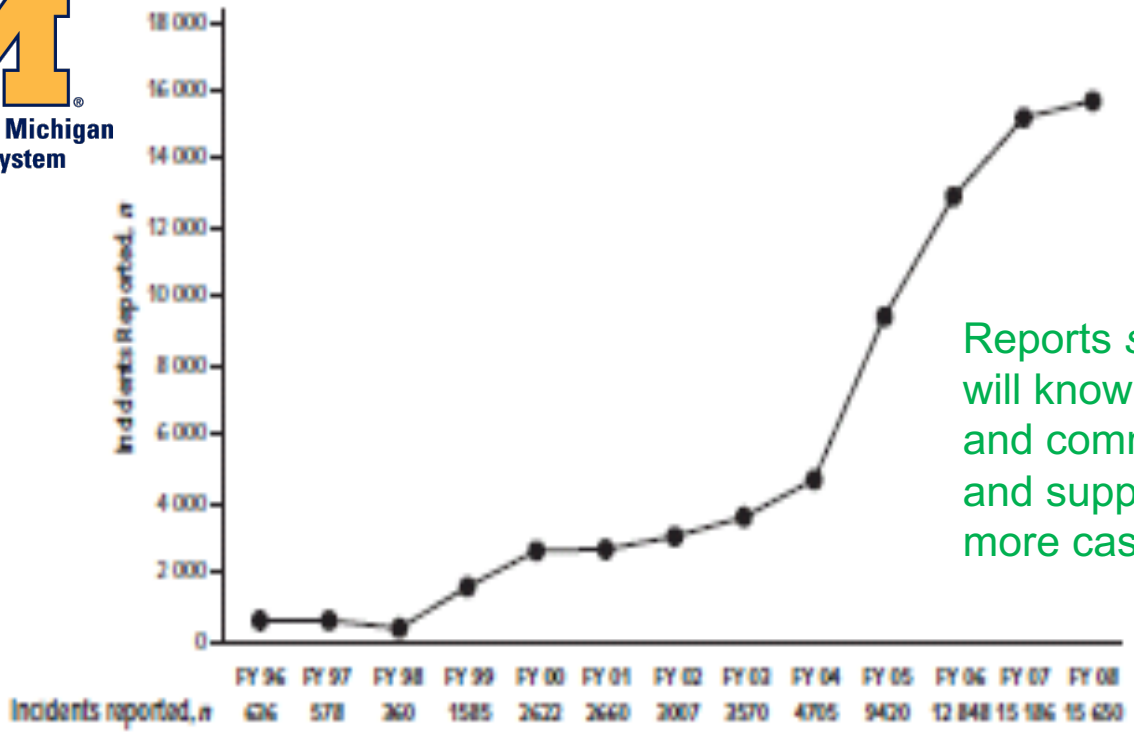
What does CARe look like?

- For a clinician
- For a risk manager
- For a patient

CARe Steps for Clinicians following an Adverse Event

- **Step 1:** Report the event and get help

University of Michigan Health System



Reports *should* increase; we will know about more events, and communication coaching and support can be offered in more cases.

Steps following an Adverse Event (cont.)

- **Step 2:** Communicate with the patient/family about the event; be empathetic and use statements of regret ("I am so sorry this happened to you…"); discuss facts known at this time and do not speculate or blame others.

- A note on Apology:
  - 1. Statements of Regret – **Always!**
  - 2. Apology of Fault – **Once facts are known**

(if applicable)

Steps following an Adverse Event (cont.)

- **Step 3:** Document the communication with the patient/family in the record; facts, who was present, and results of conversation.

- **Step 4:** Check back in with the patient/family and discuss with them the findings and any systemic improvements to be made once all facts are known and root causes have been determined.

CARe Algorithms
(Internal Risk/Safety Team)

There are two CARe Algorithms:

- Immediate steps and a “filter” to determine whether an adverse event case should go through the full CARe process
  - **“Defining a CARe Insurer Case”**
- The full CARe process that will be followed if a case is selected by the filter
  - **“CARe Protocol”**

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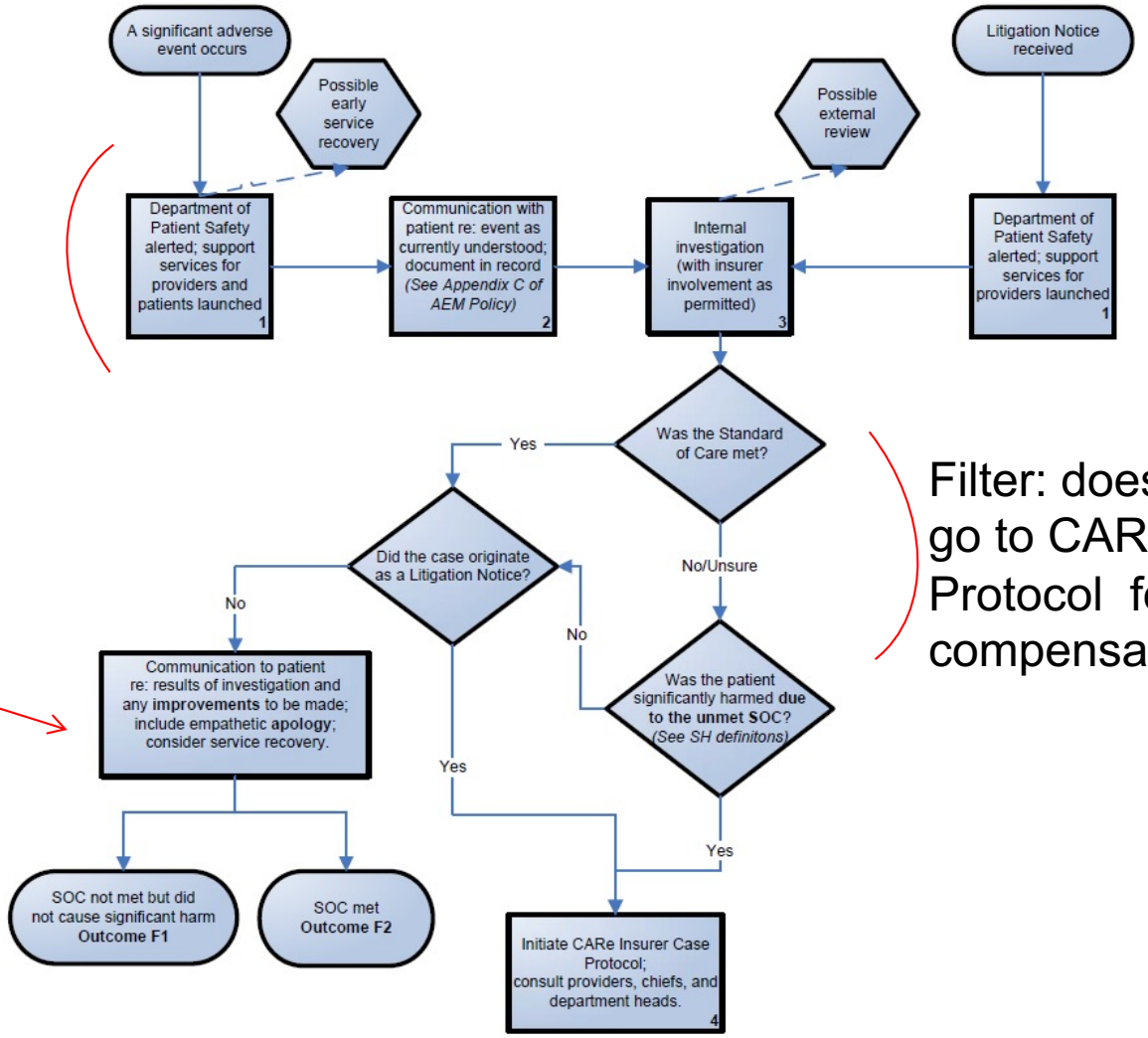
Immediate First Steps & Filter

Process followed for all A.E.s (includes support)

Service Recovery Possibility for Non-Protocol Cases



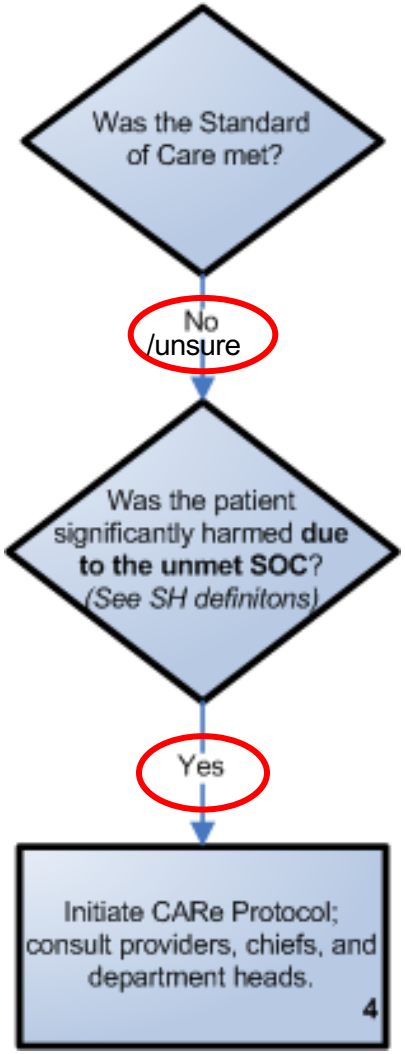
Filter: does this need to go to CARe Insurer Protocol for potential compensation?

“Defining a CARe Insurer Case” –the Filter

If an internal investigation team determines that…

- The standard of care was **not** met, AND
- The unmet standard of care **caused** significant harm

…the case moves to the full **CARe Protocol**



CARe Insurer Case Protocol

- If selected by the “filter,” case is referred to Insurer as CARe case
- Case reviewed by insurer and external experts
- CARe cases will proceed with a meeting with insurer, patient, patient’s attorney, and providers (if applicable) to formally apologize, discuss the case, and offer compensation

Communication, Apology and Resolution Timeline

Within…

24-48 hours	2-4 weeks	1-3 months	2-5 months	3-6+ months
Patient Safety Alerted Support services for providers and patients launched Discussion with patient regarding error and known facts **(1,2)**	Internal investigation takes place Patient Safety and Patient Relations maintain contact with providers and patients respectively **(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 **(4,5)**	Insurer reviews case and develops offer parameters Provider/System Allocation by insurer Insurer invites patient to CARe Initial Meeting; recommends that counsel also attend Lessons learned implemented at site **(6,7,8,9)**	Initial meeting with insurers, providers, patient safety staff, patient, counsel, and other parties. Additional meetings occur as necessary. Final offer to patient made and accepted or rejected. **(10,11)**

What else helps CARe succeed?

- Leadership buy-in
- Baseline culture of safety
  - Root cause analysis and safety improvement
  - Integration of risk management and patient relations
- Staff
  - A program manager
  - Commitment from risk management/patient safety
- Support
  - Clinician Peer Support
  - Patient resources

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Implementation Lessons Learned

- 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 well

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Lessons Learned (Continued)

- Support
  - Providers (clinician peer support; help understanding CARe)
  - Patients (Patient Relations; MITSS; social work; help understanding CARe)
- Reinforcement
  - Re-education and reaffirming the CARe process throughout the institution helps to make a cultural change

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Contact Information

Contact info:
Alan Woodward, MD, FACEP
woodward@me.com

Evan Benjamin, MD, MS
Evan.benjamin@baystatehealth.org

Melinda Van Niel, MBA, CPHRM
mvanniel@bidmc.harvard.edu

Please visit the MACRMI website for downloadable resources, blogs, discussion boards, and more :www.macrmi.info.