5th Annual CARe Forum – Session 2

Massachusetts Medical Society
April 13, 2017

#MACRMI5

Forum Objectives – Session 2

- Recognize situations in which a CARe case should move to an insurer, and describe the required steps and pitfalls in that process.

- Describe patient feedback about CARe programs and outline steps new and existing programs can take to act on that information.

MACRMI: What's New

Accomplishments, Resources, and Case Trace

Melinda B. Van Niel, MBA, CPHRM

Program Manager, Massachusetts Alliance for Communication and Resolution following Medical Injury

Massachusetts Alliance for Communication and Resolution following Medical Injury

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.

Accomplishments since 2016 Forum

- Data analysis for pilot projects completed
- Grew CARe Suggested Attorney List
- Published Article on Attorney Representation in *Healthcare Professional Liability Review*
- Added **New MACRMI Members**!
  - Newton Wellesley Hospital
  - Brigham and Women's Hospital
  - Brigham and Women's Faulkner Hospital
- Developed and Updated Resources

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.

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If you are an attorney who would like to be part of this list, please Contact Us.

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New and Updated Resources

- ***New* A Guide to Insurer Referral Conversations (with Video)**
- ***Updated* Algorithms, Policies, Implementation Guide and Templates**
  - Based on patient feedback research
- List of all MACRMI-developed Resources in your packet
- Coming Soon… Best Practices for Insurers in CARe Programs

Guide to Insurer Referral Conversations

- Community voiced a need for:
  - Suggested language when meeting with a patient and believing a case requires referral to Insurer
  - Help guiding consistent approach for all those that meet CARe Criteria, regardless of the patient's disposition
- First Panel is based around this resource and discussion

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Updated Resources

- Based changes around feedback from patients who participated in CRPs
- Research by Michelle Mello, Jennifer Moore, and Marie Bismark not yet published; we will hear more in Panel 2

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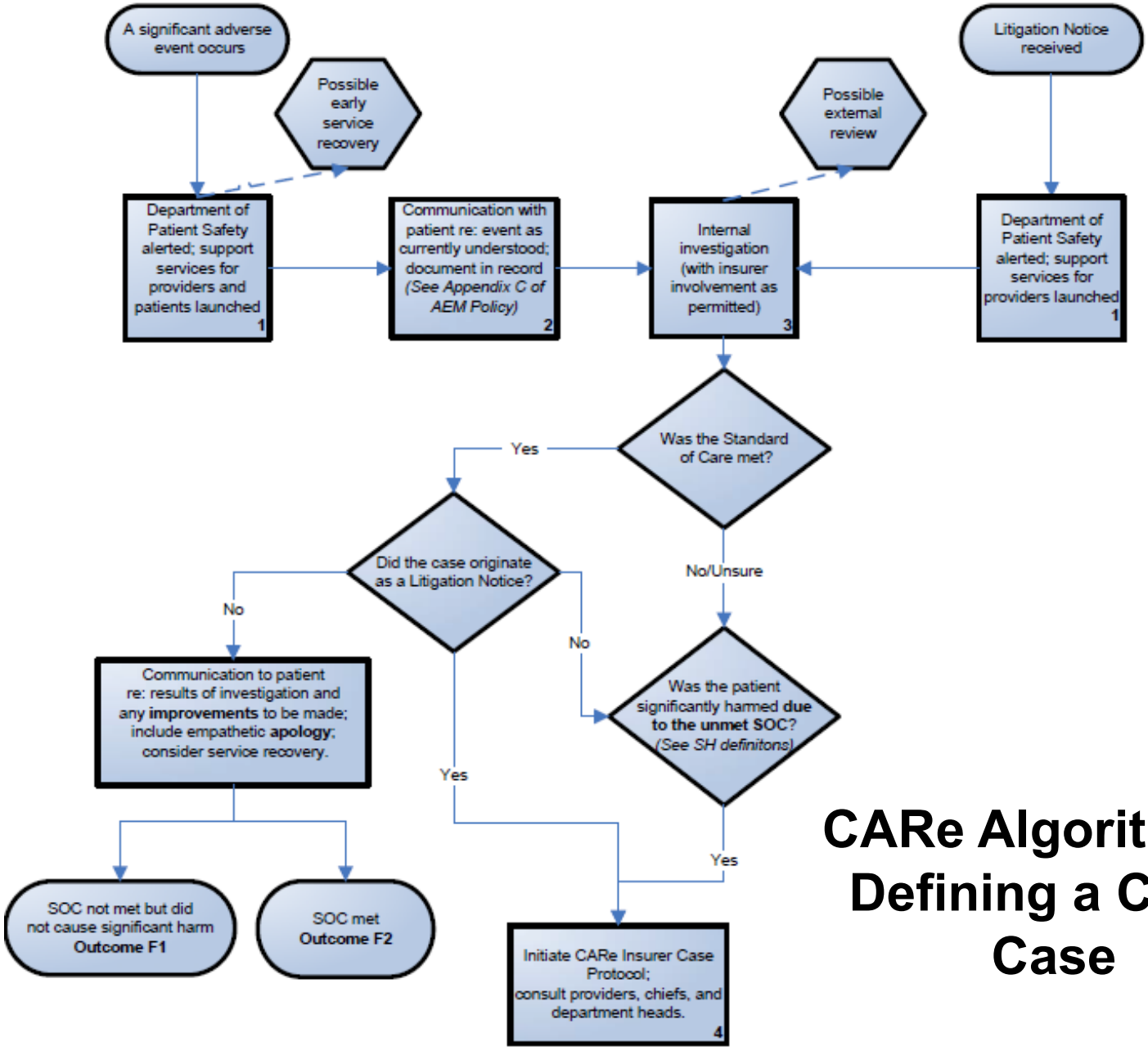
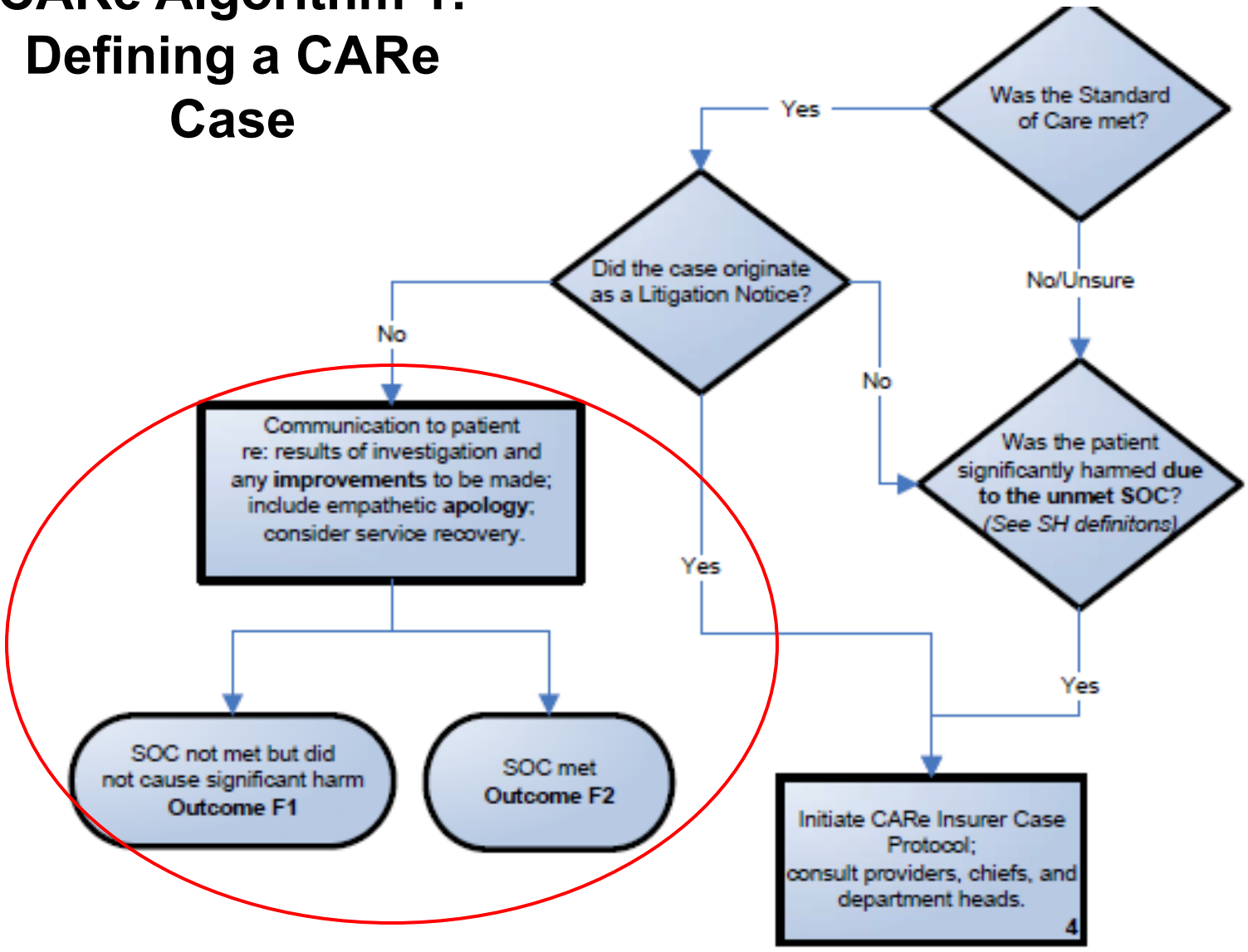


CARe Algorithm 1: Defining a CARe Case

CARe Algorithm 1: Defining a CARe Case



Updated Templates for Patient Safety Procedures and Communication Policies

- Language added to emphasize findings that many patients prefer to
- 1. hear directly from involved providers, that
- 2. patients should be moved to private rooms if at all possible, and
- 3. that written summaries of discussions are helpful.

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Templated Department of Patient Safety Procedure

much as is determined to be helpful by all parties involved. If a patient does not wish a provider to be present, then the provider will not attend the meeting. At the meeting, the following should occur:

a. A full disclosure of the error(s), cause(s), responsible provider(s), system failures(s), and *corrective action(s)* should occur at the beginning of the meeting.

b. Following the disclosure, an apology for the error and the harm it caused should occur. If possible, this apology should come from the provider(s) responsible for the error(s).

c. Then, a discussion of a financial offer that will make the patient whole will take place.

It is also recommended that the patient/family be sent a summary letter of the meeting highlighting the main points of discussion for their reference. These should be tailored to the specific situation – not form letters.

For more detailed guidance on the first meeting, please see Appendix G: "Guidelines for Initial CARe Meeting."

6. Discussions will continue until such time that the parties determine that further discussions will not be fruitful.

7. If patient accepts an offer, paperwork releasing the hospital and involved provider(s) from further action will be required (distributed by Insurer). The process should typically be completed within six months. See Appendix E for more detailed information on the timeline.

MA DPH Serious Reportable Event Letter Templates

*Name of Department Head***
Position

*** When listing department in a letter to patients, if possible, it is encouraged to use Department names like Patient Safety, Safety Improvement, Patient Relations or Healthcare Quality. It is has been demonstrated that "Risk Management" appears threatening to some patients.*

LETTER SENT TO PATIENT *30* DAYS AFTER EVENT

Dear ,

Thank you for your patience with us as we worked to better understand the causes of [the event you experienced] during your recent hospitalization here at _____. As promised in an earlier letter and in our discussions, I am writing to give you the results of the investigation we have completed.

We determined that the medical event did meet the criteria of a Serious Reportable event that is outlined by the Department of Public Health, which means it is something that they want to know about for general healthcare tracking and future policy development. [However, our investigation found that the event was not preventable – there was nothing we could have done at the time to stop it from happening, although we are very sorry that it did happen.]

OR

[We found that the event was preventable. We are very sorry that this happened, and we have put the following in place to minimize the chances of it happening again{…}

We would like to work with you to help repair the injury and losses you have incurred because of this preventable event through our Communication, Apology and Resolution (CARe) program, which you

Implementation Guide

Institutional Education

18) Review CARe presentation templates and revise as necessary for your institution. We recommend customizing the presentation for each audience, and have found in particular that a presentation to leadership has different goals than a presentation to physicians or other clinicians, and the presentations should reflect this. (Sample presentation attached.)

19) Look for broad opportunities to promote the CARe program including a story on your internal portal or your institutional or different departmental magazines/publication/newsletter

20) Create a presentation guide. Use a spreadsheet to outline all the different departments at your facility, and the leaders of those departments. This will be your guide to ensure that you've reached all staff at your institution. Revisit these departments at least annually with an update and a reminder to continue to increase awareness.

21) 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.

22) Add CARe information into your new physician/staff curriculum presentations.

Case trace

- You have a case where a patient calls you to voice a concern about the care received. He says he was admitted to the hospital to resolve back pain he had that went untreated after a surgery.

- How to use MACRMI Resources to help you bring this case through the CARe process?*
- *Remember that CARe is a whole program built on relationships and communication; it is not designed to be a one-off process

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

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

HORIZON INTERACTIVE AWARDS BRONZE WINNER

MARCOM AWARDS

Other suggestions for resources? Let us know in your evaluation!

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CARe Evaluation Results

5th Annual MACRMI Forum
Waltham, MA
April 2017

Allen Kachalia, MD, JD
Michelle Mello, JD, PhD

BWH

STANFORD SCHOOL OF MEDICINE
Stanford University Medical Center
Stanford Law School

Panel Discussion

Data Analysis Results and Resources

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Break

Please return to your seats by 2:30pm for our panel presentations

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Panel Discussion

CARe Insurer Cases: The First Step in Possible Compensation Cases

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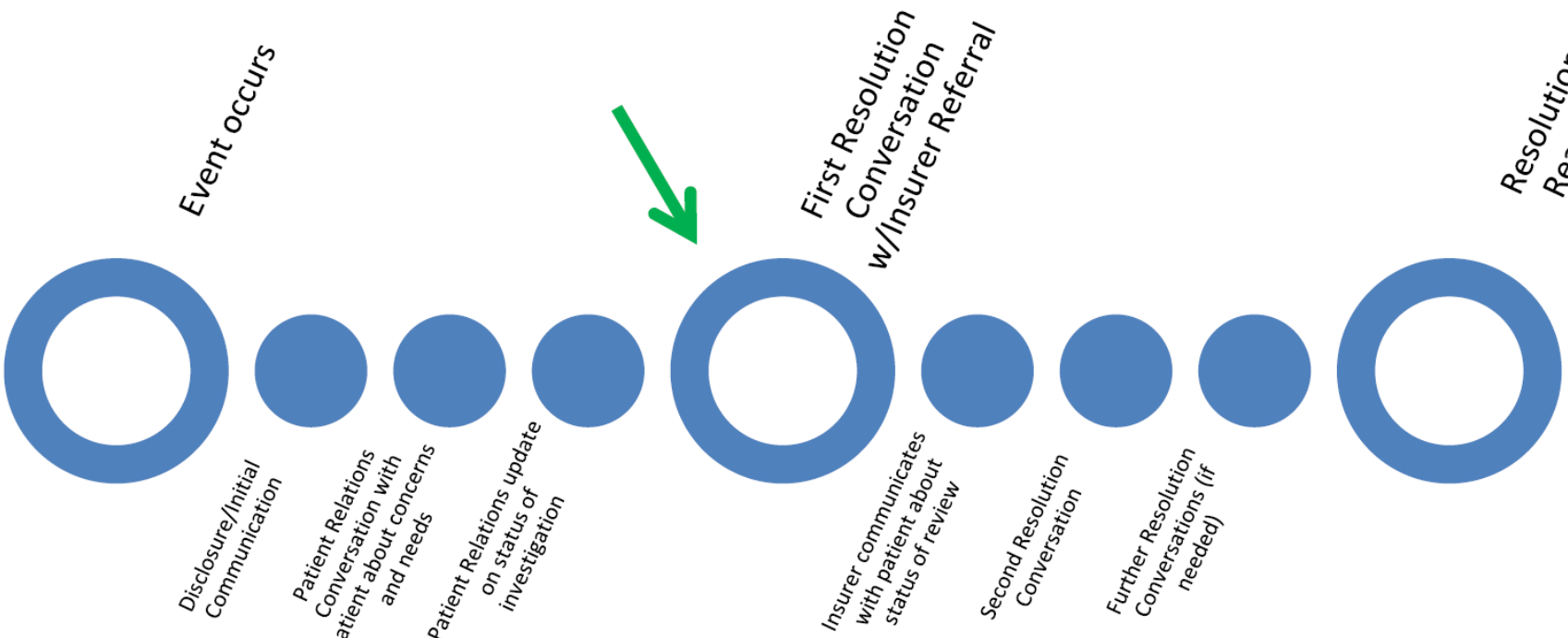
A Guide to Insurer Referral Conversations (in packet)

- A case is referred to an insurer in the CARe process if compensation greater than small service recovery could be warranted.
- Typically these are cases where the hospital's internal investigation found that 1) the care provided was unreasonable (or the team is unsure whether it was reasonable or not), *and* 2) that the care caused the patient significant harm.
- This referral conversation should only occur after discussion and collaboration with the insurer about the event and plan to refer patient/family to them.

Where this Conversation Fits



Example - Video

- In this scenario, Mrs. Moore was admitted to the hospital for an appendectomy. After her procedure, she was feeling very nauseous; the was given Zofran, to which she had a severe and known allergy.
- This resulted in cardiac arrest. The code team was delayed in arriving, and permanent heart damage resulted.
- The hospital does not believe it met its standard of care, as they gave Mrs. Moore this medication without using the proper processes to check her allergies.

Example - Video

- Video clip of this discussion between Patient Relations staff and Patient based on Guide to Insurer Referral Conversations

- There has already been a disclosure conversation as well as phone conversations about the progress of the investigation with this patient prior to this meeting

Video Clip

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Panel Discussion

CARe Insurer Cases: The First Step in Possible Compensation Cases

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Panel Discussion

Where CRPs can do better:

A Study of Patient Participants

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Panel Discussion

Where CRPs can do better:

A Study of Patient Participants

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Communication and Resolution Programs

blurry present, hopeful future

Richard C. Boothman

Chief Risk Officer, Michigan Medicine

Executive Director of Patient Relations and Clinical Risk

5th Annual MACRMI Forum

April 13, 2017

University of Michigan Health System

The blurry present

- **Goal is to build and support a culture of continuous improvement and service to mission**
- **Clinical accountability via honesty, transparency is indispensable**
- **Systematic and normalized**
- **Consciously create internal and external expectations**
- **Principled, consistent, courageous**
- **Relentless service to the mission requires a consistent and principled response to every single patient, and one-by-one, you'll create a cultural expectation**

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Essential Elements of a true CRP

Notification of unintended clinical outcome	Stabilize the clinical environment and protect other patients	Support the patient, listen, promise full disclosure
Support the caregiver, listen, promise full disclosure	Normalize honesty, rigorous investigation and review	Share facts and conclusions openly with caregivers and patients alike
Be principled and accountable. Compensate where warranted, consistent in peer review	Leverage lessons learned in safety, quality and peer review in continuous quality and safety improvement	Measure improvement, communication, normalized, consistent, transparent and relentless

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Characteristics of this model . . .

- Risk management, insurance, legal serves the big picture (ie, the clinical mission), and,
- Conversely, risk, insurance and legal must not inhibit the big picture
- Fair compensation paradigm (principally based on the harm caused) must be part of the continuum of any accountable culture – seen as an investment in ourselves
- Normalize honesty as a fundamental expectation because our clinical mission, and all that serves the mission like patient centricity and continual improvement, requires it

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Attributes

- Systematic
- Relentless
- Normalized
- Jealously guarded
- Principled
- It's stubbornly clinical until it's not
- Locked and focused on the core clinical mission, uniting patients and caregivers in a singular mission: to put patients at the center of all we do

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the blurry present

- **Inherent tension: claims (short term) vs core mission (long term)**
  - AHRQ grantees' experience – rich lessons learned
  - Learn from health systems that have tried and failed (VA, U of Ill-Chicago)
  - Some health systems earnestly moving in this direction – will they be stalled at claims management? (U of Florida, Ascension, Dignity)
  - Aspirants (Oregon Patient Safety Commission, state hospital associations like Connecticut, Utah, Minnesota)
  - Poseurs (those who want to be included, but have no intention of actually moving past claims management, service recovery)
  - Abusers (some may abuse early claims practices)

From: Jenkins,Randall C [mailto:jenkinsr@ufl.edu]
Sent: Monday, February 20, 2017 10:47 AM
To: Boothman, Rick
Subject: Hi from Florida

Hi from Florida! You may not recall speaking with me years ago around 2006-2007 as UF Health instituted our mandatory mediation program for all patients before they bring suit so that we have a chance to speak openly with unhappy patients in a protected mediated environment before we all begin the expense delay and uncertainty of our American legal system. We are just about to publish our 8 year results in the journal of conflict resolution and I will be sure and send you a copy when its ready if you are interested. The program has been a wonderful place to apologize and share information even if the care provided was defensible. I have enjoyed following the great work you have done over the years at Michigan and beyond.
Many thanks for always being helpful. Randy

Randall C. Jenkins, Esq.
Administrator
University of Florida J. Hillis Miller Health Center Self-Insurance Program
Clinical Associate Professor, University of Florida

University of Michigan Health System

Collaborative for Accountability and Improvement

Plans for Upcoming Year

- Training
  - Continue national trainings
  - ACHE C-suite and Board program presented by CAI/NPSF/IHI
- Best Practices & Standards
  - Standards for institutional CRPs
  - Best Practices & Standards Subcommittee
- Outreach
  - Marketing CRP message
  - Communication & Outreach Subcommittee
- Research
  - Evidence base around CRPs
  - Research Task Force

University of Michigan-Michigan Hospital Association training program

- The University of Michigan and the Michigan Hospital Association partnership
- Inspired by MACRMI's success and model
- Credible, consistent, principle-based-yet-nimble
- Regional
- Successful models to emulate
- Leverages the state hospital association network
- Available to large hospital systems and international groups
- Self perpetuating

UM/MHA Training Center

UM offers:

- IP
- Content, materials
- Some faculty
- Laboratory for site visits
- Experience and brand credibility
- Scholarly/research platform – potential "home" for the Collaborative
- International outreach

MHA offers:

- Operational/admin staff
- Business platform
- Faculty
- Facilities
- Marketing
- Publishing
- Leverage leadership and experience with large patient safety "spread"
- State and local outreach

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Thank you

Closing Remarks

Alan Woodward, MD

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Evaluations

- To receive credit for attending you must fill out an online evaluation that will be sent within the next week.
- In order to receive that evaluation, you must have checked in at the registration desk.
- Please suggest any new resources or topics for next year's forum in that evaluation!

Thank you!

Please see our website, www.macrmi.info, or contact Melinda Van Niel at mvanniel@bidmc.harvard.edu with any questions.

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