The 7th Annual Communication, Apology and Resolution Forum

Hosted by MACRMI in joint providership with
the Massachusetts Medical Society

With special thanks to the Coverys Community Healthcare Foundation

May 7, 2019

#CARe2019

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Objectives

- Describe how the CARe process works behind the scenes for risk managers, providers, and claims representatives

- Recognize the benefits of CARe programs to physicians, patients, and healthcare institutions and understand how to realize those benefits with the program

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Disclosures

- The Massachusetts Medical Society has determined that none of the individuals in a position to control the content of this CME activity, and/or their spouse/partner have any relevant financial relationships with commercial interests to disclose.

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Introduction:
MACRMI and CARe

The basics of CARe and what MACRMI has to offer

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

- **Communicate** with patients and families when unanticipated adverse outcomes occur, and provide for their immediate needs.
- **Investigate and explain** what happened.
- Implement systems to **avoid recurrences** of incidents and improve patient safety.
- Where appropriate, **apologize** and work towards **resolution** including an offer of fair compensation without the patient having to file a lawsuit.

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The “Difference Makers”

- Every case, every time
- Being proactive, particularly when it would be easy to hang back

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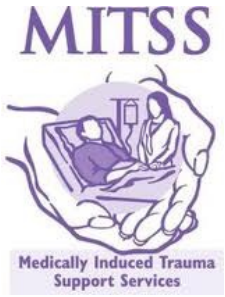

Joining MACRMI - Benefits

1. Free implementation guidance by members who have built CARe programs from the ground up
2. Free tools and resources, and assistance using them
3. Community of experienced individuals from systems of different sizes, models, and locations to discuss challenges with
4. Wider community of members involved in all aspects of medical liability to learn from and work with

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MACRMI's Resources

- CARe Best Practices for institutions, attorneys, and insurers
- Patient Brochure and Information Sheet
- Site Readiness Checklist for Implementation
- Sample policies / procedures for facilities + algorithms
- CARe FAQs for Patients, Providers and Attorneys
- Slide decks and other resources for teaching the concepts to clinicians
- Implementation Guide (comprehensive)
- Articles and supportive evidence: Latest HA article free until June 4th!
- New Inventory of Patient Safety Improvement Spread ideas from CARe cases

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Website: www.macrmi.info

Joining MACRMI - Requirements

- **1.** Implement the CARe Program system-wide to follow the Algorithms and Best Practices of MACRMI.

- **2.** Submit basic data regarding algorithm outcomes to MACRMI quarterly.

- **3.** Attend MACRMI meetings (quarterly, plus a Forum).

Today

- **2 Simulations**

Newton Wellesley Hospital	Beth Israel Deaconess Medical Center
Community Hospital	Academic Medical Center
Type of case = standard of care not met, caused significant harm to patient	Type of case = standard of care met even though there was significant harm
Resolution: Compensation	Resolution: Communication

- **Data presentation**
- **Keynote**
- **Chair closing address and networking**

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It was a happy accident that I was naïve to the ways of a big organization

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Early lessons

- Did not ask for permission, but captured caregivers and clinical leaders
- Saw the clinical mission long-term
- Not bound by accepted divisions between quality, safety, peer review and risk – it's all in service to a central goal: serving the patient
- Publicly picked a side ("I don't serve you well by defending substandard care" "I don't serve you well by litigating unnecessarily") but by stubbornly focusing on the central clinical mission it was clear that patients would directly benefit

Take-aways

1. Cannot avoid asking permission now, but can and must connect with clinical leaders and staff – more permissive than persuasive
2. Stay focused on the central mission, look for the broader benefits
3. There are a million reasons why it won't work - do not be deterred
4. Anticipate "turf issues" and be inclusive
5. Be smart: recruit your lawyers to help navigate the legal differences, protect the protections
6. Biggest early risks: assassins and those invested in the status quo
7. Clarity around claims goals: right-size for accountability, not downsize

Operational lessons and take-aways

- Risk/claims management is not valued, HR is often a hurdle
- The signal difference is the goal
- Start as quickly as possible
- Most hospitals already have what they need to get started
- Normalize normalize normalize the response to injured patients
- Legal blinders: lawyers don't always serve the clinical mission

- Training is on-the-job, recruitment is skills-based
- Changing minds is not easy

- Mind-shift isn't obvious
- Do not exhaustively plan before you start
- The sooner you normalize the better – "it's just who we are"
- Lawyers are a bigger challenge than we realize, not just in this work, but across the board

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Don’t be afraid, don’t be deterred

The University of Minnesota Physicians’ progress

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On paper, UMP should fail

- Physicians' group
- Does not own or control the main hospital UMP staffs
- Variety of clinical environments: UMP staffs other health care settings
- The University employs the trainees, is insulated liability-wise and looks to the UMP for the lead in claims (except when it doesn't)
- Three different insurance plans protected by three different trial attorneys
- Small, UMP risk management staff competes with hospital's risk dept and contends with the University's general counsel's office
- Long Minnesota statute of limitations meant that they were accustomed to long average event-to-resolution time period

Meeting fear with organizational informed consent

- Clarifying the goals, the rationale and the expected collateral benefits
- Mapping present state/inventory existing state and resources
- Map new operational flow and clarify expectations
- Set proper metrics and progress reporting expectations
- Getting started immediately

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From February to September:

- January – March: presentations to leadership, presentations to hospital/University, review of UMP data, inventory resources and talent, meeting with prominent plaintiff's and defense attorneys
- April: detailed review of existing cases, develop strategic plan for each
- May: detailed map of transition from present state to future model, education/negotiations with defense counsel, corporate leadership training in anticipation of resistance from hospital/University, recruiting outside TPA to build out metrics for periodic progress reports
- June – July: operationalize new cases and implement strategy with existing cases, coach and supervise
- September: had already worked through more than 40 cases

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Take-aways from UMP

- Courageous, committed clinical/risk management leaders are critical
  - Barbara Gold, MD, Ruth Flynn, JD, Nancy Lamo, JD
- Corporate-level support (leap of faith) is important (yet tentative)
- Disadvantages were not insurmountable
  - Physician group proved advantageous – resonated immediately
  - Skeptical patients/plaintiff's lawyers "get it" quickly and support
  - Did not need additional FTEs or other resources to start
  - Defense lawyers are more difficult – need new business model
  - Able to convert chronic employment dissatisfiers to accelerators
  - Model lifts all boats, even doubtful corporate partners

Take-aways from UMP

- Next stage: honing the operational phase, strategic communications to increase reporting, continue negotiations with hospital/University, publicizing results
- Based on success, corporate architecture change included a new role for Dr. Gold, new FTEs for risk management
- Build out the Clinical Care Review Committee to provide caregiver “voice” and ownership
- Build out care-for-the-caregiver support
- Continued case management support
- Communication communication communication communication

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Lessons learned from the field

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Other challenges and observations

- Very difficult for organizations to make the transition themselves – much baggage, corporate cultures resist change and most succumb to inertia
- Corporate leaders are unaccustomed to personal involvement in patient injuries
- The transition requires expertise to navigate the intersection of safety, quality, peer review protections with work-product and attorney-client privileges. Consultants, especially physician-consultants get stymied by skeptical lawyers and resistant insurance companies
- Few organizations have leveraged the model to realize the considerable collateral benefits in peer review and many clinical practices

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Challenges and failures

- Corporate interruptions can slow or stop progress including leadership changes and budget arguments – need to anticipate these
- After what seemed like solid success at leadership "informed consent" a client apparently got cold feet when lawyers argued it could not be done there due to legal "uniqueness"
- One project started with intention to select one hospital as a pilot site proved impossible due to the interconnectedness of the system
- As plans for ambitious operational stage were formed, a client complained of "sticker shock" and progress stopped
- Common thread: Clearly not sold on the value to their central mission, failed to cement the importance to the clinical mission, failed to impress sell significant collateral benefits

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Fidelity to the overriding purpose
makes all the difference

Challenges and failures

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Skepticism and misconceptions of the model

- "This man will singlehandedly bankrupt the University of Michigan Health System in 5 years." Acclaimed scholar, Troyen Brennan, MD, PhD, JD ***Leading Medical Reform***, University of Michigan, Nov. 24, 2004

- "This might work in the sleepy Midwest, but it will never work here." New York attorney at the Greater New York Hospital Association conference, May 13, 2005

- "You don't know what you're talking about. Just how many cases have YOU tried? I've tried more than 200 cases and you're an idiot." Defense attorney at Fallon Clinic presentation, Sept. 27, 2006 *(he was escorted out)*

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- "That severe injuries are prevalent and that most of them never trigger litigation are epidemiological facts that have long been evident. The affordability of the medical malpractice system rests on this fragile foundation, and routine disclosure threatens to shake it. Movement toward full disclosure should proceed with a realistic expectation of the financial implications and prudent planning to meet them." *Disclosure Of Medical Injury To Patients: An Improbable Risk Management Strategy*, Studdert, Mello, Gawande, Brennan, and Wang Health Affairs, January/February, 2007 HTTPS://DOI.ORG/10.1377/HLTHAFF.26.1.215

- "Why in hell would we do THIS? We're already paying out a king's ransom! You must be insane." Executive for a prominent TPA, New York, Sept. 16, 2009

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- "You should be ashamed of yourself, taking advantage of people like this." Judge Douglas E. McKeon, NY State Supreme Court, Sept. 16, 2009

- "The most commonly referenced apology program is the University of Michigan Healthcare Services model. The architect of the program is Attorney Richard Boothman . . . Attorney Boothman has become one of the most prominent proponents of apology programs in the United States. UMHS's philosophy is consistent with the concept of 'cooling the mark out'." Gabriel H. Teninbaum, How Medical Apology Programs Harm Patients 15 Chap. L. Rev. 307 (2011)

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The most important factor distinguishing authentic and durable examples from those that do not survive is the motivation for the transition

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If the primary motivation is reduction of claims and claims' cost, the program will:

- Likely be spotty, inconsistent and selective
- Be vulnerable to charges of patient exploitation
- Be dependent on the personal motivation, integrity and skill of the claims handlers and therefore, not durable

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If the primary motivation is compensation of every patient who has an unplanned clinical outcome, the program will:

- Likely be spotty, inconsistent and selective
- Demoralize its clinical staff
- Undermine the patient/provider relationship
- Introduce financial pressures that likely will be counterproductive to safety, quality and patient centricity

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If the primary motivation is service to the clinical mission and the reason healthcare providers work in health care the program will:

- Be consistent
- Be understandable to patients and staff alike
- Relentlessly serve the central clinical mission
- Save money in the short run by avoiding unnecessary litigation but more importantly (and durably) by improving clinical care safety and quality

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A final story – why we do this

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Thank you

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Closing Comments

Ashley Yeats, M.D.

Thank You

Bagged lunch and networking in lobby.

MACRMI members (red stickers on name tags) are here to chat with!

Visit us at www.macrmi.info for resources and more.

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