# The 8th 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

## Virtual Forum - September 21, 2020

This session is being recorded for those who cannot attend live. We will take questions through typing box.

# Objectives

- Describe how the CARe process works behind the scenes for healthcare institutions

- Recognize the barriers to implementation of CARe and understand strategies for overcoming them

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Disclosures

- The Massachusetts Medical Society (MMS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) and must ensure independence, objectivity, balance and scientific rigor in all its educational activities. All individuals in control of the content, including faculty, course directors, and planners (and their spouse/partner) participating in any MMS activity must provide information about potential conflicts of interest that may be relevant to the activity. Listed below is a summary of disclosure information of relevant financial relationships within the past 12 months for individuals (and their spouse/partner) in control of content with any entity producing, marketing, re-selling or distributing health care goods or services consumed by, or used on, patients. All potential conflicts of interest have been identified and resolved prior to the beginning of this activity in accordance with MMS policies.

- The faculty member listed below disclosed the following financial relationship:

  Richard Boothman, JD Boothman Consulting Group LLC Owner & Principal

- All other individuals in control of the content for this activity have reported no relevant financial relationships.

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# CME/Nursing Credit

After attending today's session you will receive a link to an evaluation (this can take up to 1 week). Once that is completed, you will receive a link to a CME certificate for download.

If you are a nurse, email the CME certificate to Melinda Van Niel (mvanniel@bidmc.harvard.edu) for nursing credits.

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Today's Agenda

- Background:
  - What is CARe, and why do we use it?
  - Review of published data
  - MACRMI and its resources
- Panel 1: *Reflections from the Field*
- Panel 2: *Addressing CARe Barriers*
- Closing Remarks
  - 30 minutes additional open question time

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Introduction:
# MACRMI and CARe

The basics of CARe and what MACRMI has to offer

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# 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.

A better way to resolve adverse events for patients, providers, and the healthcare system

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Why CARe?

| Deny and Defend | | CARe |
|---|---|---|
| Reactive | → | Proactive |
| Culture of secrecy | → | Increased reporting/transparency |
| Denial | → | Apology (and healing) |
| Individual blame | → | System repair |
| Patient/MD isolation | → | Supportive assistance |
| Fear | → | Trust |
| Defensive medicine | → | Evidence-based medicine |
| Lengthy | → | Efficient |

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# How it works

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

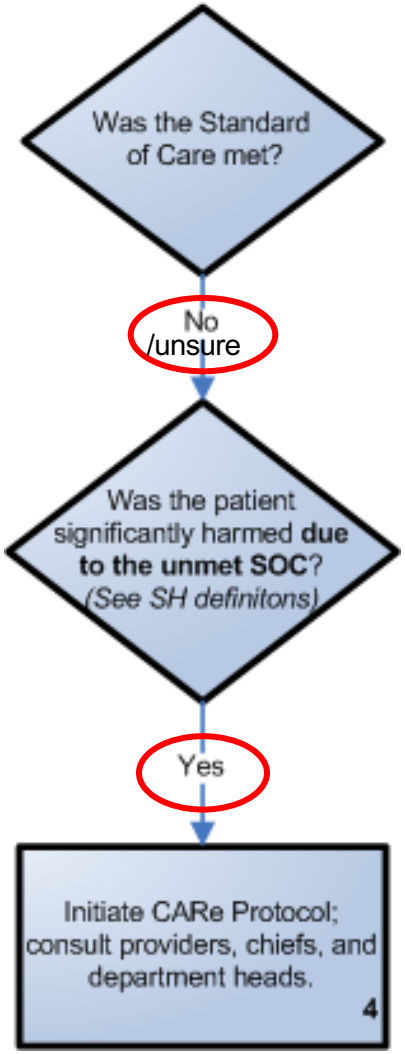
# “Defining a CARe Insurer Case” - the Filter

*“Every case, every time”*

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 Insurer Case Protocol**



# CARe Insurer Case Protocol

- If selected by the “filter,” case is referred to Insurer as CARe Insurer case
  - Insurer will have been alerted to possibility previously
- Case reviewed by insurer and external experts as insurer determines necessary in collaboration with facility
- CARe cases will proceed with a meeting(s) with insurer, patient, patient’s attorney, and providers to formally apologize, discuss the case, and offer compensation
- Communication remains a high priority throughout

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Non- Protocol Cases

- The majority of our cases do not meet the filter's criteria of a CARe Insurer case (only 16% in our study did)
- But these cases are **equally important** as they have entered the algorithm because **they necessitate good and proactive communication**, and our primary job in risk/safety is to ensure that happens.
- This may mean additional letters, calls, and meetings with a patient who had an "expected complication" or other harm that was not preventable.
- Good will gesture also an option for these cases

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# The “Difference Makers”

- Every case, every time
- Being proactive with patients
- Communication, communication, communication!

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Data

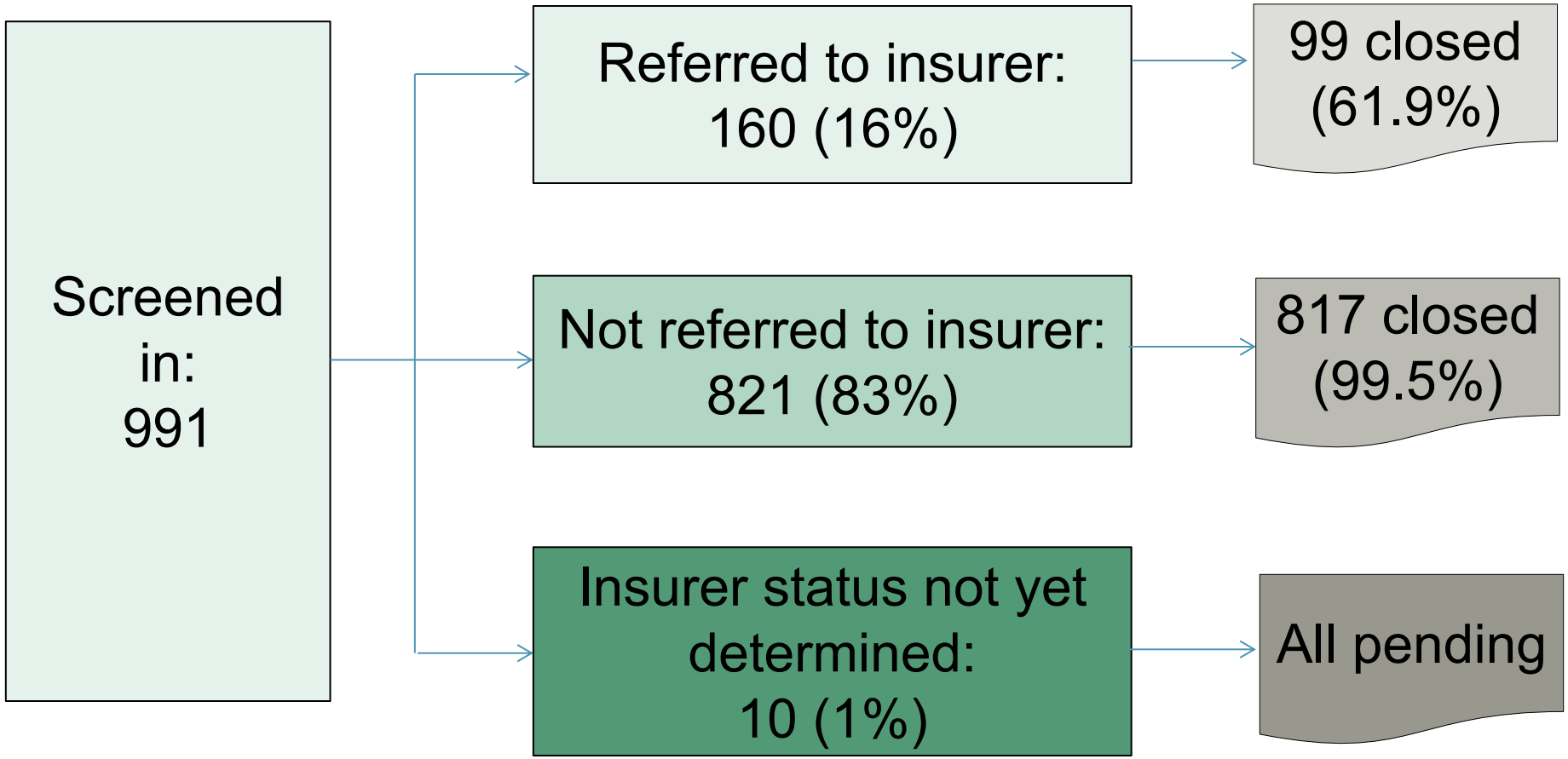
MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# The Massachusetts Pilot Sites

| Site | #Beds | Location | Teaching (Y/N) |
|---|---|---|---|
| Beth Israel Deaconess Medical Center | 642 | Urban | Y |
| BID-Milton | 88 | Community | N |
| BID-Needham | 58 | Community | N |
| Baystate Medical Center | 716 | Urban | Y |
| Baystate Franklin Medical Center | 93 | Community | N |
| Baystate Mary Lane Hospital | 31 | Community | N |

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Cases tracked in MA study



# Results: Were there any statistically significant changes ($p \leq 0.05$) in liability trends?

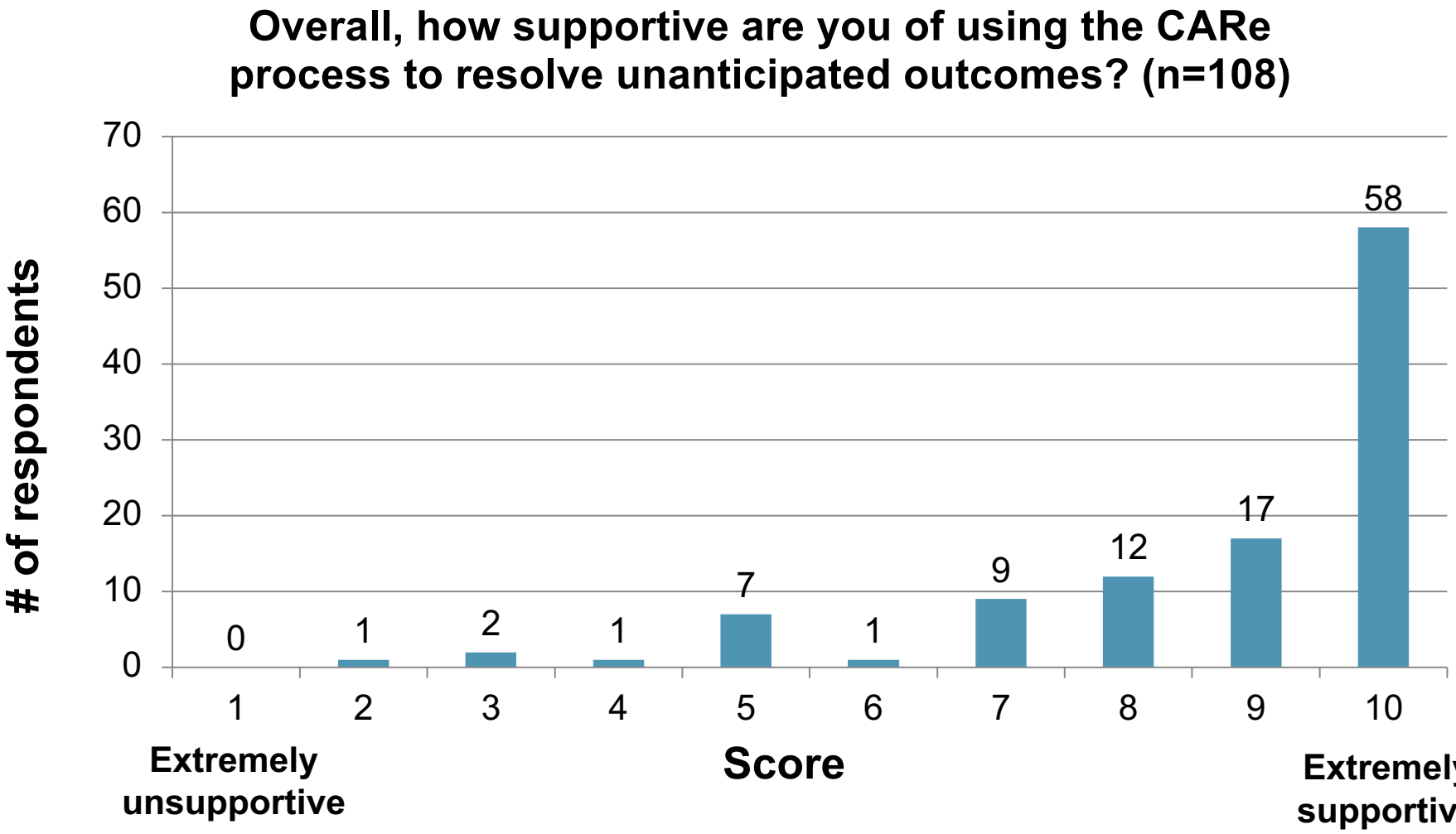
| Outcome | CARe CRP Hospitals | Comparison Hospitals (No CRP) |
|---|---|---|
| New claims | **Lower at community hospitals and 1 academic medical center** | No change |
| Defense costs | **Lower at both academic medical centers** | No change |
| New claims receiving compensation | No change | No change |
| Compensation costs | No change | No change |
| Average payment per claim | No change | No change |
| Time to resolution | No change | No change |

# Conclusions from MA Study

- Large cost savings reported by some early adopters did not occur, but there were **no cost increases and some significant decreases**
- Hospitals can “do the right thing” without increasing their liability exposure
- Providers involved in cases supportive of CARe overall

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Providers are supportive of CARe overall




* 74 respondents said they did not know enough to answer this question.

# Conclusions (con't)
## Factors Facilitating Successful Implementation

- Deep engagement by high-level physician champions
- Strong buy-in from risk management
- Practical support and oversight by project managers
- No barriers erected by insurer
- Pre-existing just culture commitment
- Sense of community and support from MACRMI

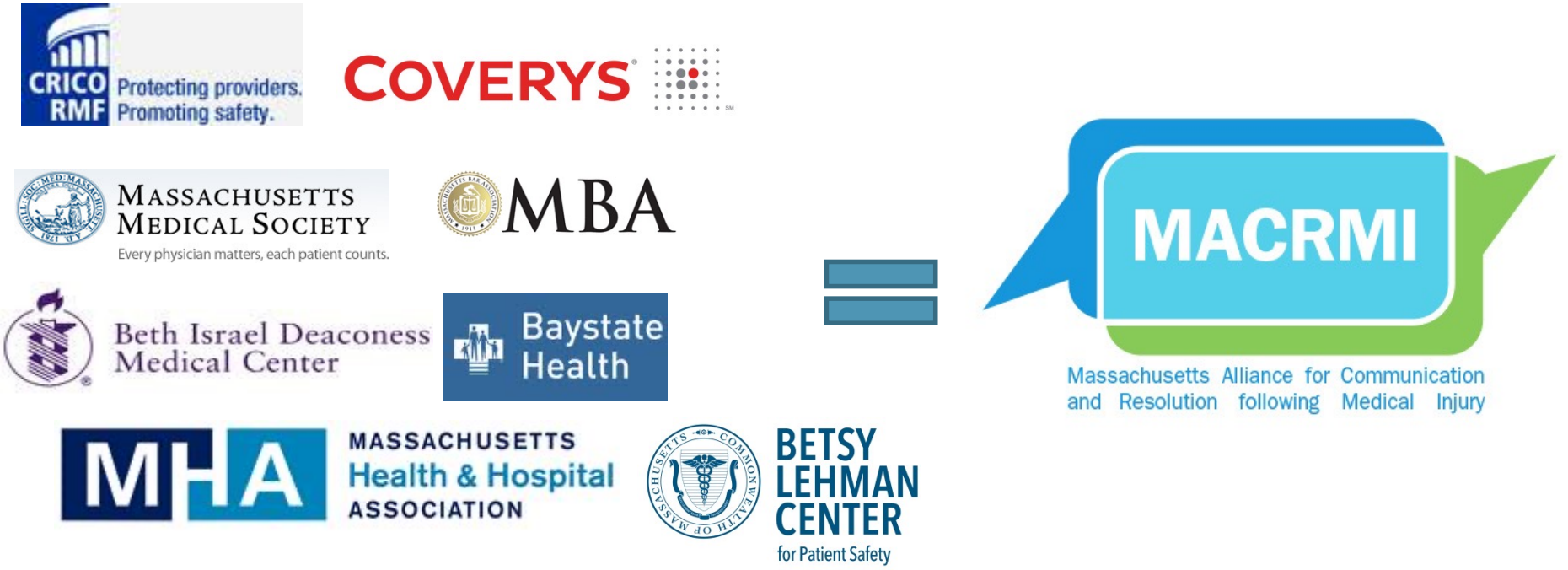
MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# MACRMI

Who we are and what we do

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Massachusetts Alliance for Communication and Resolution following Medical Injury

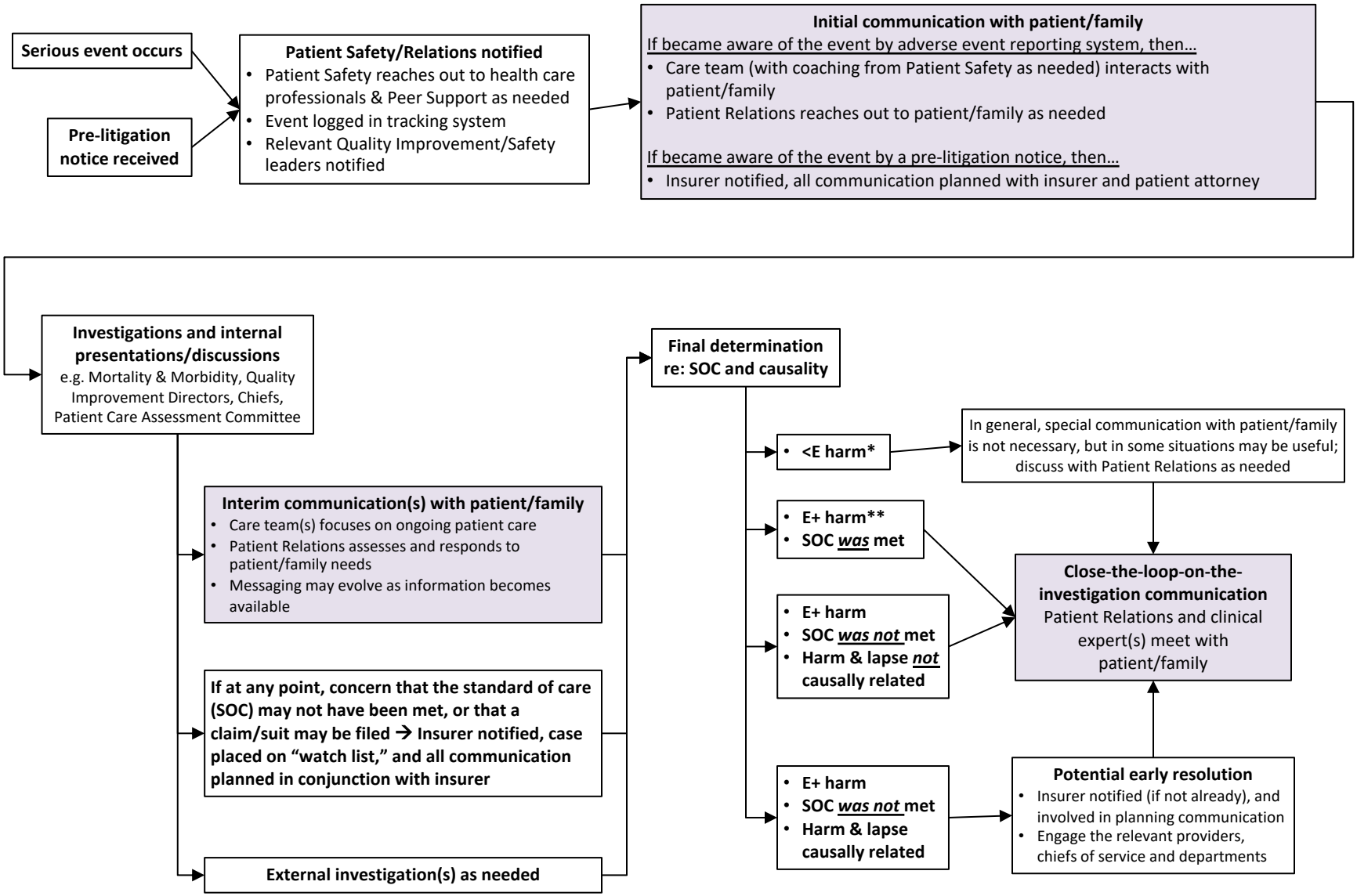


# MACRMI's Resources

- 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
- Comprehensive Implementation Guide
- New! Clinician Communication Algorithm

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Clinician CARe Communication Algorithm




*Using NCC-MERP Scale as letter reference
**Minor temporary harm to the individual that required intervention of < 3 follow up visits and did not require an additional procedure

## Initial communication

**Care team (with coaching from Patient Relations as needed) interacts with patient/family**

**DO SAY**

- *"We are so sorry this happened to you."*
- *"We're not yet sure why this happened."*
- *"We are going to do an investigation to try to figure out why this happened."*
- *"We will be in touch once we have learned more."*
- *"Right now, our primary focus is on making sure you get the care you need."*
- *"We are going to connect you with someone in patient relations who you can contact at any time. They can help you get in touch with us and get answers to other questions you may have.*

**DON'T SAY**

- *"We have been in touch with our Risk Manager/Insurer"*
- Don't speculate, e.g. *"We're not sure you needed that procedure" or "That other hospital didn't know what they were doing"*

**Patient Relations interacts with patient/family as needed**

- Express empathy and reiterate your role and contact information.
- If uncertain about whether the SOC was met, consider early service recovery, e.g. paying for parking.
- The patient/family may indicate they do not want to be contacted by Patient Relations, or they may simply not respond to outreach from Patient Relations. In the latter situation, Patient Relations should stop attempting to contact them after 2 phone calls and 1 letter asking them to reach out when ready.

## Interim Communications

**Care team focuses on ongoing patient care**

Their communication stays focused on current state and future care, not on the adverse event. See prior tips about DOs and DON'Ts for initial communication. Direct questions about the investigation to Patient Relations.

**Patient Relations interacts w/patient/family as needed**

**DO SAY**

- *"How are you doing?"*
- *"Is there anything we can do to facilitate your care?"*
- *"We are continuing to look into why this happened."*
- *"We want to be very thorough in our investigation so we can prevent this from happening again."*
- NOTE: if there are indications that the SOC was not met, additional early service recovery may be indicated

**DON'T SAY**

- *It takes a really long time for these cases to be reviewed.*

**Situations where it is unclear whether the SOC was met, or where it's unclear if lapses in the SOC were causally related to the harm can be particularly complex, and it may take a longer time to make a final determination. In such situations:**

**DO SAY**

- *"We want to be very thorough in our investigation so we can prevent this from happening again."*
- *"We take these events very seriously and want to give your event the time and attention it deserves. We expect to be done with the comprehensive review in about [x weeks] but I will let you know if that changes."*

**Close-the-loop-on-the-investigation communication**

**Patient Relations and clinical expert(s) meet w/patient/family**

- *"Thank you for coming to meet with us. We would like to share the results of our investigation into why this happened, and make sure we address any questions you might have."*
- Explain what happened, matter-of-fact, patient-centered language, pausing to allow opportunities for questions/clarifications.

- **E+ harm**
- **SOC *was* met**

- *"Unfortunately, our investigation determined there was no way to prevent what happened to you."*
- *"As a result of this case, we recognized an opportunity to make some improvements… they wouldn't have prevented what happened to you, but they may help prevent harm to other patients."*
- *"We're so sorry this happened to you."*
- After the meeting, provide a written summary of the clinical details that were discussed.

- **E+ harm**
- **SOC *was not* met**
- **Harm & lapse *not* causally related**

- *"Unfortunately, our investigation determined that while we wish we had done some things differently, the harm you experienced was not preventable."*
- *"In other words, even if your care had been flawless, we believe you still would have experienced what you did."*
- *"As a result of this case, we recognized an opportunity to make some improvements… they wouldn't have prevented what happened to you, but they may help prevent harm to other patients."*
- *"We're so sorry this happened to you."*
- After the meeting, provide a written summary of the clinical details that were discussed.

**Usually one such conversation is sufficient. In some situations, additional meetings with patients/families may be needed if they think of more questions.**

- **E+ harm**
- **SOC *was not* met**
- **Harm & lapse causally related**

**Potential early resolution**

- Insurer notified (if not already), and involved in planning communication
- Engage the relevant providers, chiefs of service and departments

**If all agree with proceeding with early resolution program**

- *"So in summary, our investigation determined that your experience may have been preventable. [based on particular circumstances of case]"*
- *"We're making some changes to try to prevent future patients from experiencing what you did."*

**Patient Relations and/or Patient Safety representative will discuss the CARe program Insurer Review and possible compensation with the patient and family. Such discussions usually take place at the end of this meeting, and clinicians are typically not present.**

**Future communication is between the patient/family (+/- their attorney) and the insurance claims rep (+/- others as needed)**

**If disagreement about valuation of harm → attempt mediation**

**If disagreement about proceeding with early resolution → typical malpractice pathway**

**Close-the-loop-on-the-investigation communication**

**Patient Relations and clinical expert(s) meet w/patient/family**

- *"Thank you for coming to meet with us. We would like to share the results of our investigation into why this happened, and make sure we address any questions you might have."*
- Explain what happened, matter-of-fact, patient-centered language, pausing to allow opportunities for questions/clarifications.

- **E+ harm**
- **SOC *was* met**

88%

- *"Unfortunately, our investigation determined there was no way to prevent what happened to you."*
- *"As a result of this case, we recognized an opportunity to make some improvements… they wouldn't have prevented what happened to you, but they may help prevent harm to other patients."*
- *"We're so sorry this happened to you."*
- After the meeting, provide a written summary of the clinical details that were discussed.

- **E+ harm**
- **SOC *was not* met**
- **Harm & lapse *not* causally related**

2%

- *"Unfortunately, our investigation determined that while we wish we had done some things differently, the harm you experienced was not preventable."*
- *"In other words, even if your care had been flawless, we believe you still would have experienced what you did."*
- *"As a result of this case, we recognized an opportunity to make some improvements… they wouldn't have prevented what happened to you, but they may help prevent harm to other patients."*
- *"We're so sorry this happened to you."*
- After the meeting, provide a written summary of the clinical details that were discussed.

**Usually one such conversation is sufficient. In some situations, additional meetings with patients/families may be needed if they think of more questions.**

- **E+ harm**
- **SOC *was not* met**
- **Harm & lapse causally related**

10%

**Potential early resolution**

- Insurer notified (if not already), and involved in planning communication
- Engage the relevant Providers, Chiefs of service and Departments

**If all agree with proceeding with early resolution program**

- *"So in summary, our investigation determined that your experience may have been preventable. [based on particular circumstances of case]"*
- *"We're making some changes to try to prevent future patients from experiencing what you did."*

**Patient Relations and/or Patient Safety representative will discuss the CARe program Insurer Review and possible compensation with the patient and family. Such discussions usually take place at the end of this meeting, and clinicians are typically not present.**

**Future communication is between the patient/family (+/- their attorney) and the insurance claims rep (+/- others as needed)**

**If disagreement about valuation of harm → attempt mediation**

**If disagreement about proceeding with early resolution → typical malpractice pathway**

*Data based on two academic medical center sites over 1 year; percentages similar to data from other sites in 3-year pilot study.*

# Website: www.macrmi.info

# Panel 1:
# Reflections from the Field

***Barbara Fain, JD***, Executive Director of the Betsy Lehman Center

***Evan Benjamin, MD***, Chief Medical Officer at Ariadne Labs

***Richard C. Boothman, JD***, Communication and Resolution pioneer and founder of Boothman Consulting, Inc.

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

BETSY LEHMAN CENTER
for Patient Safety

# Alleviating the Emotional Impact of Medical Harm

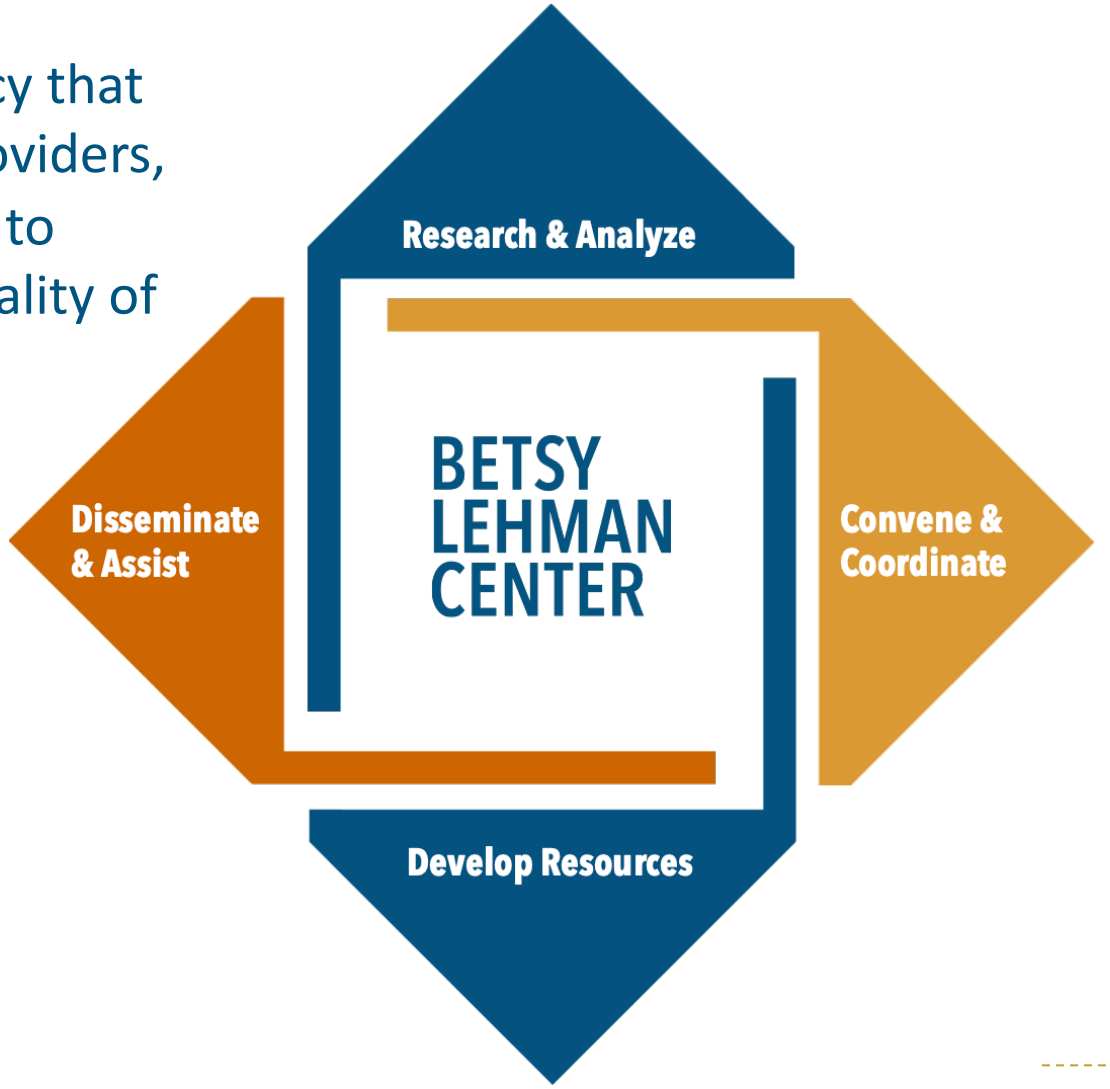
## A statewide survey's implications for CRPs

Barbara Fain, Executive Director

September 21, 2020

# The Betsy Lehman Center is…

… a non-regulatory Massachusetts state agency that **catalyzes** the efforts of providers, patients and policymakers to advance the safety and quality of health care in all settings



# Research question

*How does the **Massachusetts public** experience medical error?*

# Specifically …

If we ask a **large, randomized cross-section** of Massachusetts residents about their experiences with medical error, what will we learn about …

- The **incidence** and **types** of medical errors in the Commonwealth?
- The health care **settings** where errors are happening?
- The **physical, emotional, and financial consequences** of error to patients and families over time?
- **How providers respond** after an error (e.g., do they disclose, apologize, offer help)?
- The impact of **open communication** about errors on patient and family wellbeing?

# Methodology

**STEP 1**

Included two questions in CHIA's 2017 **Massachusetts Health Insurance Survey (MHIS)** to identify residents who have experienced medical error

- **1 in 5 of the 5,001 residents** surveyed by phone reported one or more errors in their own care or in the care of a member of their household or extended family in the past 5 years

**STEP 2**

In summer 2018, fielded a **Re-contact Survey** of MHIS medical error respondents for in-depth interviews about their experiences

- Completed **253 phone interviews** averaging 30 minutes
- Questionnaire included open-ended **narrative questions** as well as multiple choice questions

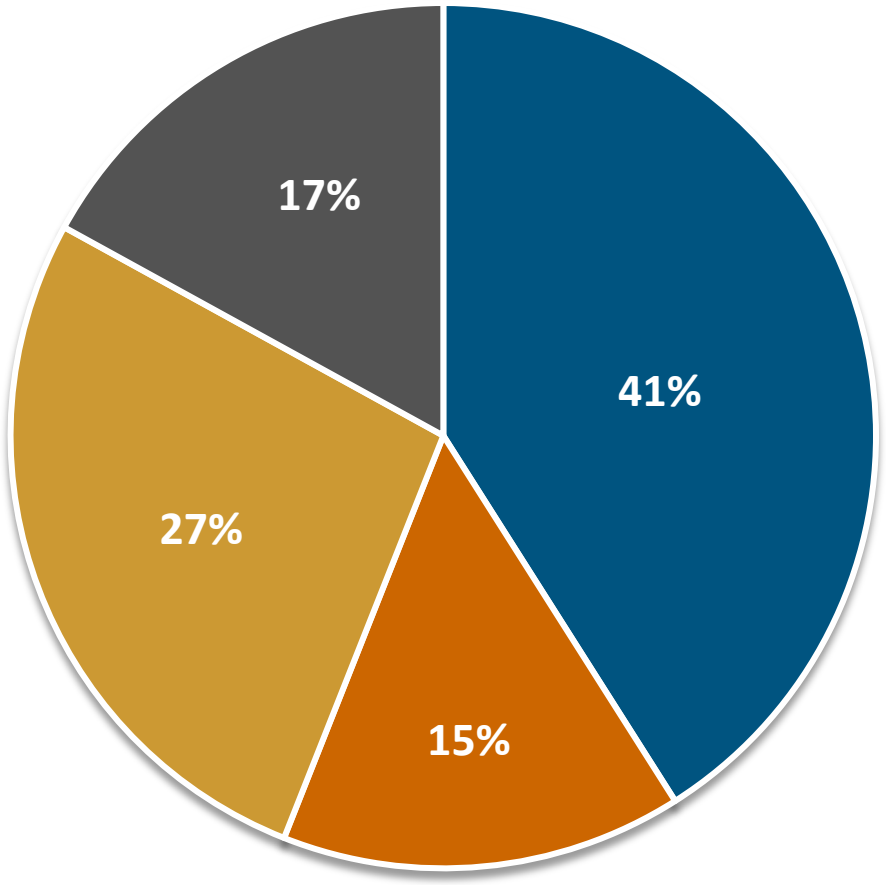
***First statewide survey to both rigorously measure public experience with medical error and capture patient narratives***

# How we defined **“medical error”**

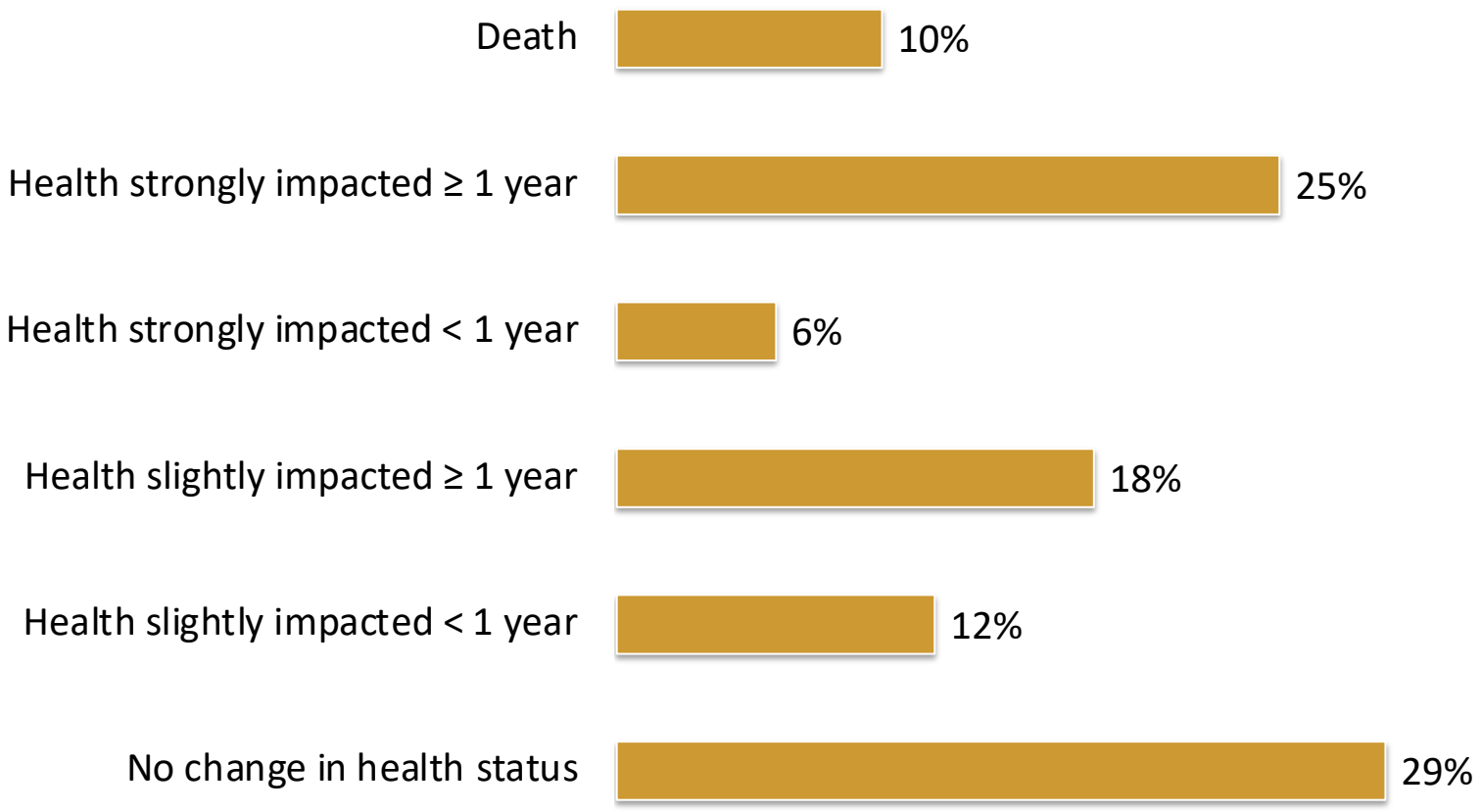
BETSY LEHMAN CENTER for Patient Safety

*“Sometimes when people receive medical care, mistakes are made. These mistakes sometimes result in no harm; sometimes they may result in additional or prolonged treatment, disability, or death. These types of mistakes are called medical errors.”*

# Medical errors happen in **all** health care settings



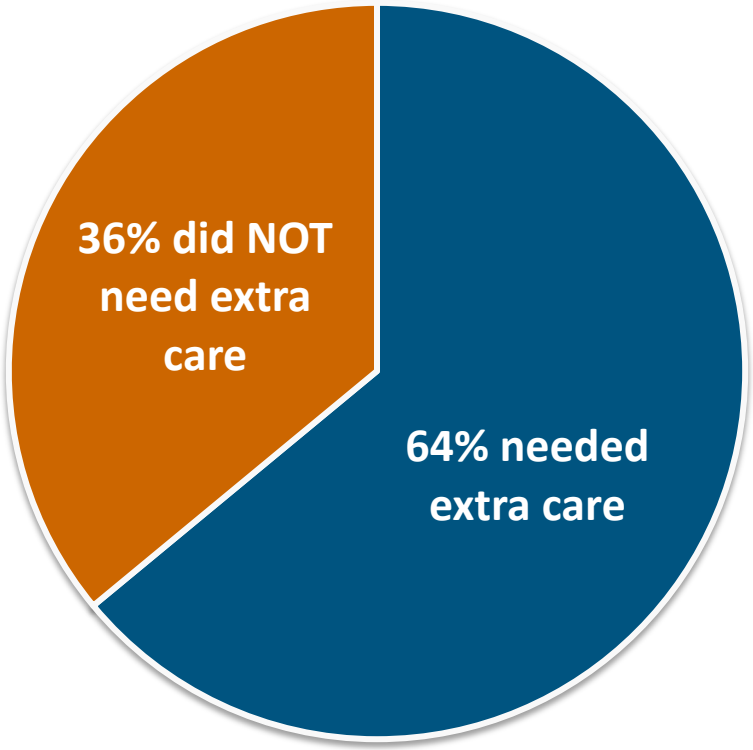
# Medical errors have long-lasting impacts on **physical** health




Excludes respondents whose error happened <1 year before survey

# Most errors result in a need for additional medical care …

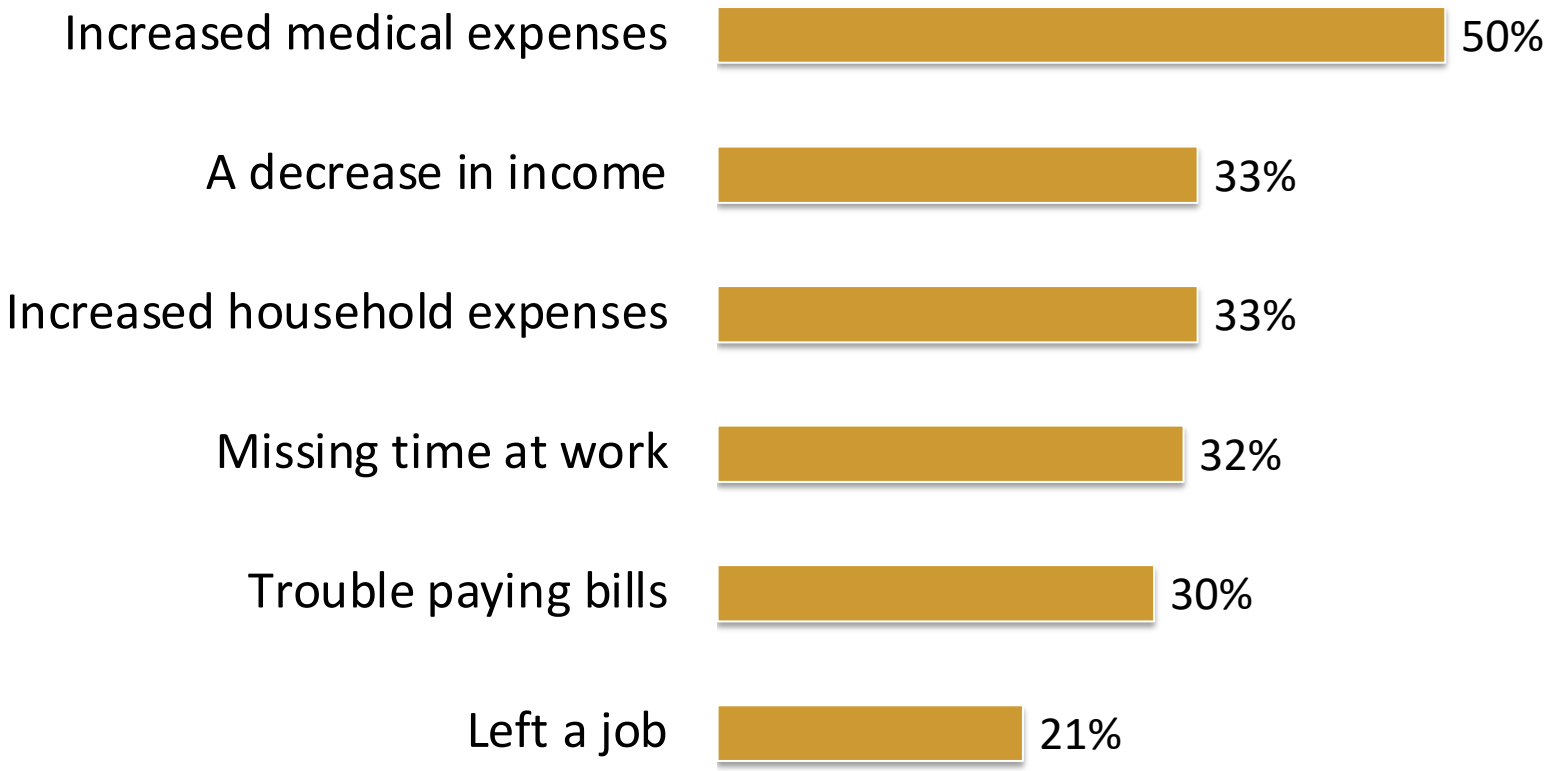
**… such as longer hospital stays, rehabilitation services, or extra doctor visits**



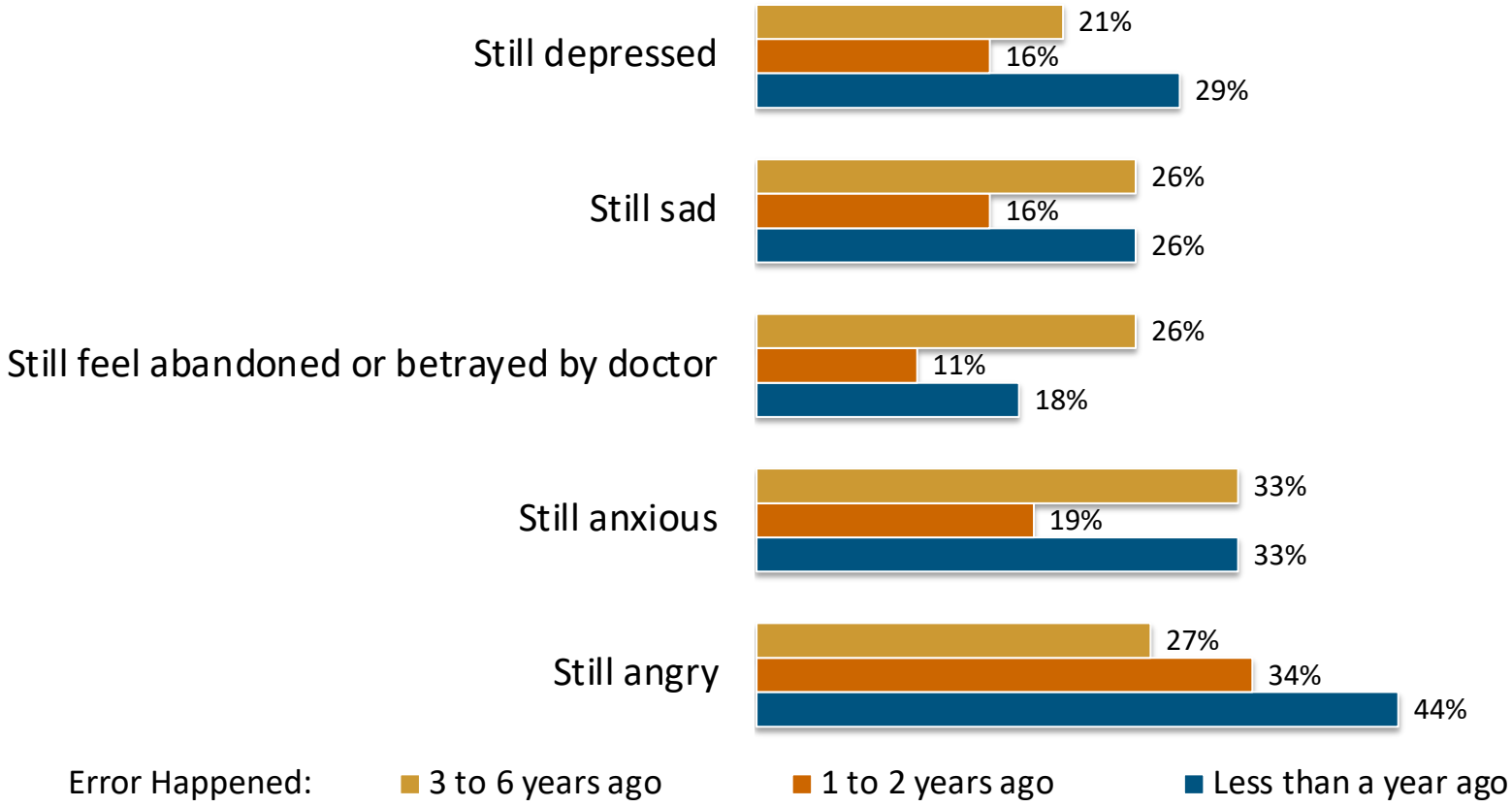
# Medical error adversely impacts patient and family **finances**

BETSY LEHMAN CENTER
for Patient Safety and Medical Error Reduction

***Nearly half report 2 or more of these impacts***



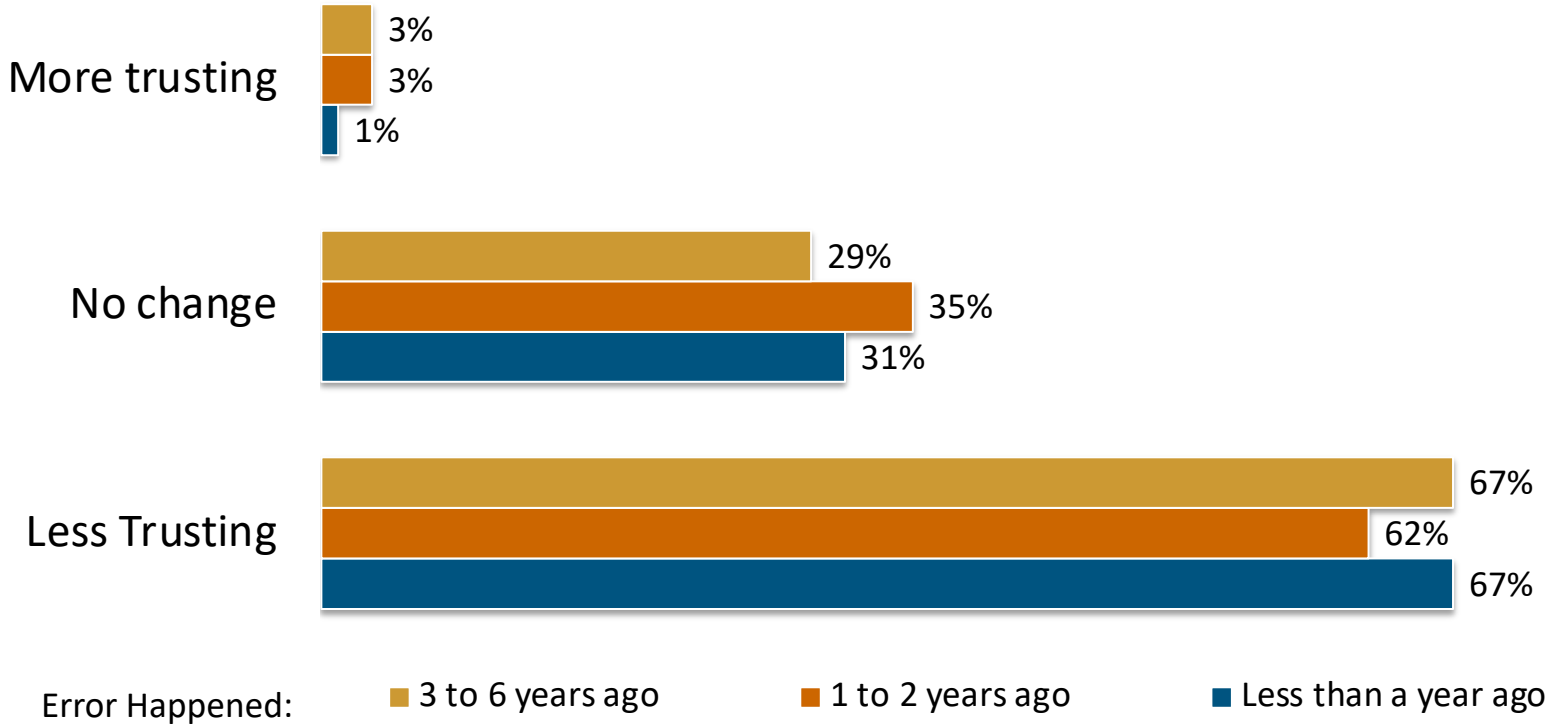
# Medical errors have long-lasting impacts on **emotional** health




*I just get stressed out constantly. And I am furious because this is the mess they created and they just threw me out the door, which was even worse."*

– She suffered complications from an unnecessary surgery

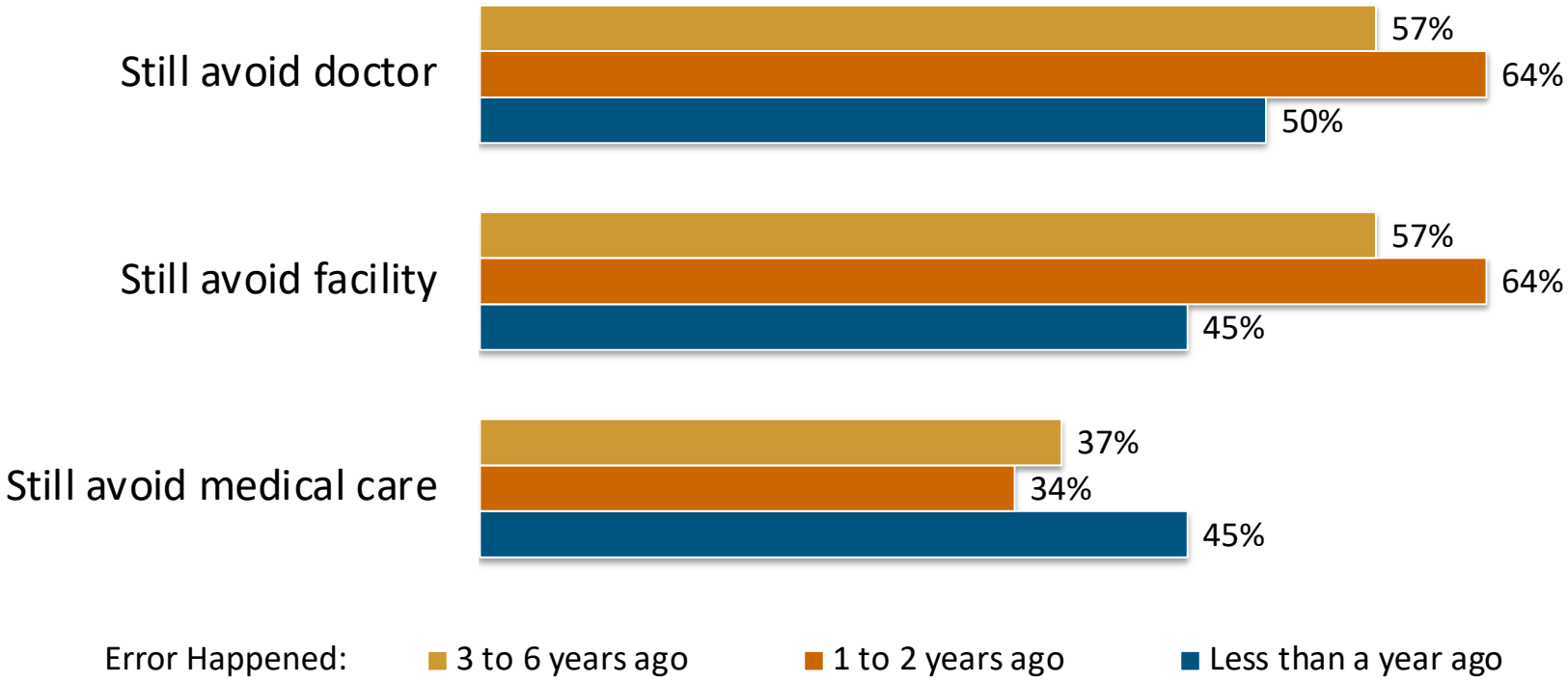
# Medical errors cause long-lasting **loss of trust** in health care




*"The hardest part is the cynicism and guardedness I continue to have for everyone in the medical field. I have no trust left."*

– A clinician refused to reconsider a diagnosis that turned out to be wrong, leading to additional complications

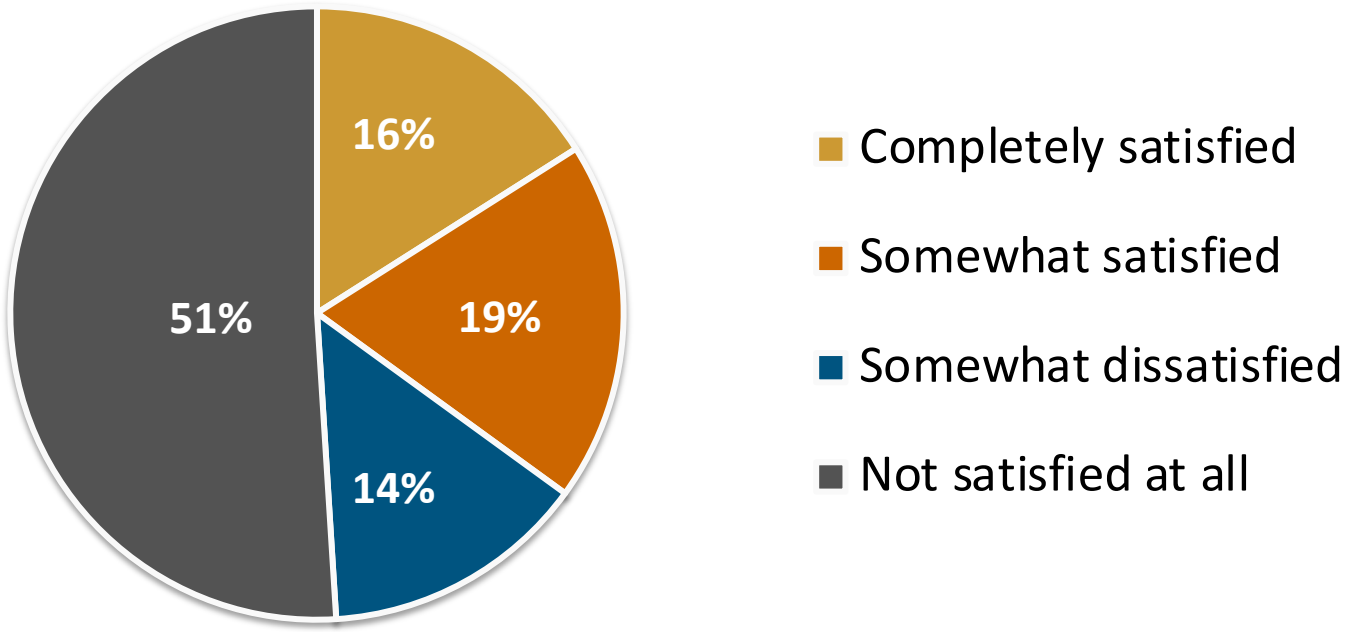
# People often **avoid health care** for a long time after an error




*"I stay away from medical [care]. I stay away from it as much as possible. I use alternative resources, try and go holistic."*

– Repeated hospitalizations from a surgical error put this mother of young children out of work for months

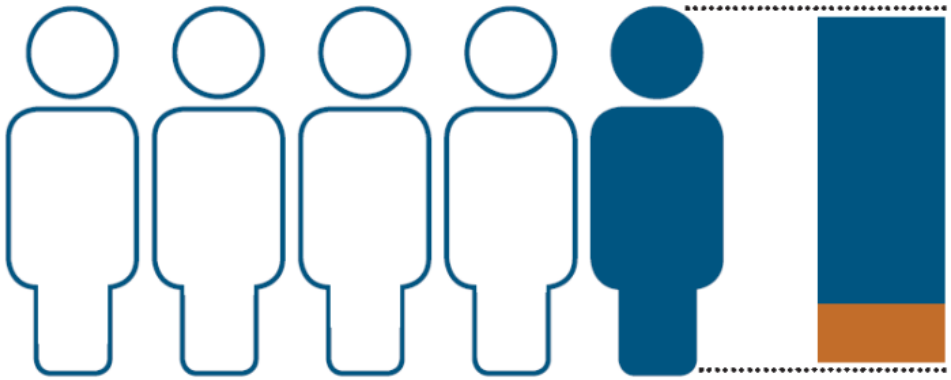
# 2 out of 3 patients and family members are **dissatisfied with care team communication** after an error




*"Any acknowledgment of their mistake, or a recognition that they need to be better listeners, would be nice."*

– Clinician failed to recognize seriousness of infection despite patient's concerns, delaying treatment

# **Apology** is still the exception after an error

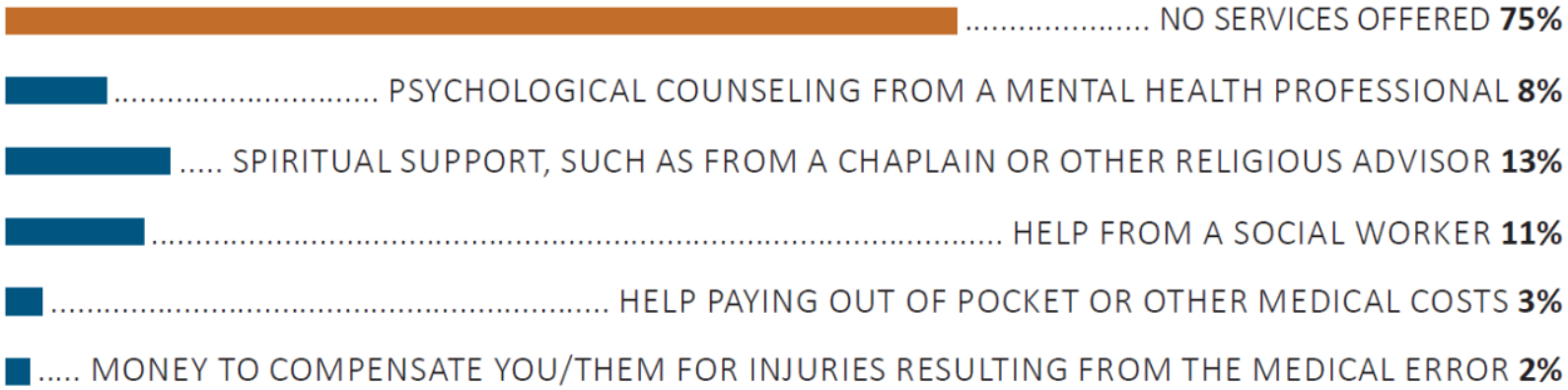


Fewer than one in five say they received apology following medical error.

Sincere **82%**

Majority who received apology felt it was sincere.

# **Offers of support** are infrequent

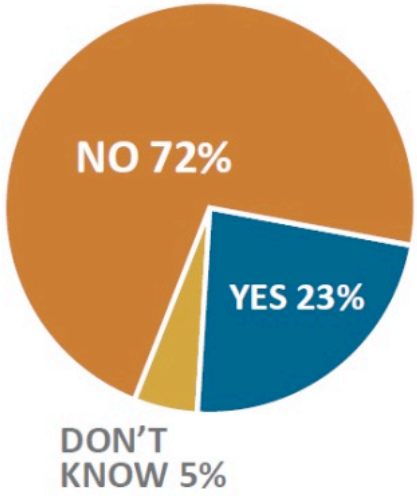



*"Well, first thing [that would have helped] would have been to acknowledge and apologize that mistake had been made. And I think secondly, I did incur out-of-pocket costs to have the procedure done again, and those should have been covered."*

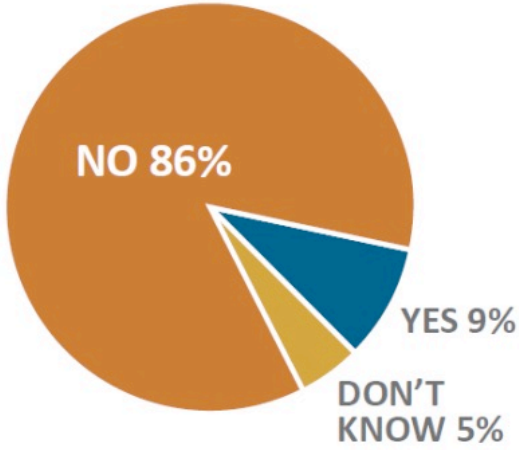
– He had to have a second procedure because of an error

# **Actions** being taken in response to the error are rarely shared

Did provider explain any follow-up actions to prevent similar errors in the future?

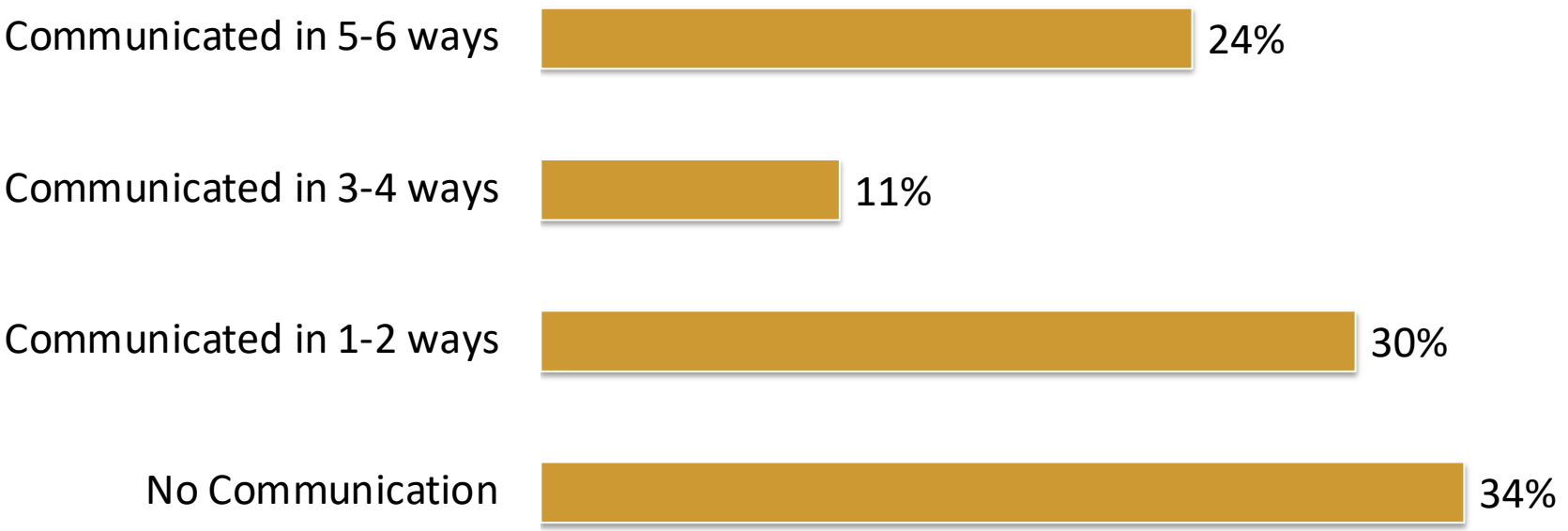



Did provider offer information about a review or investigation to determine what caused the error?

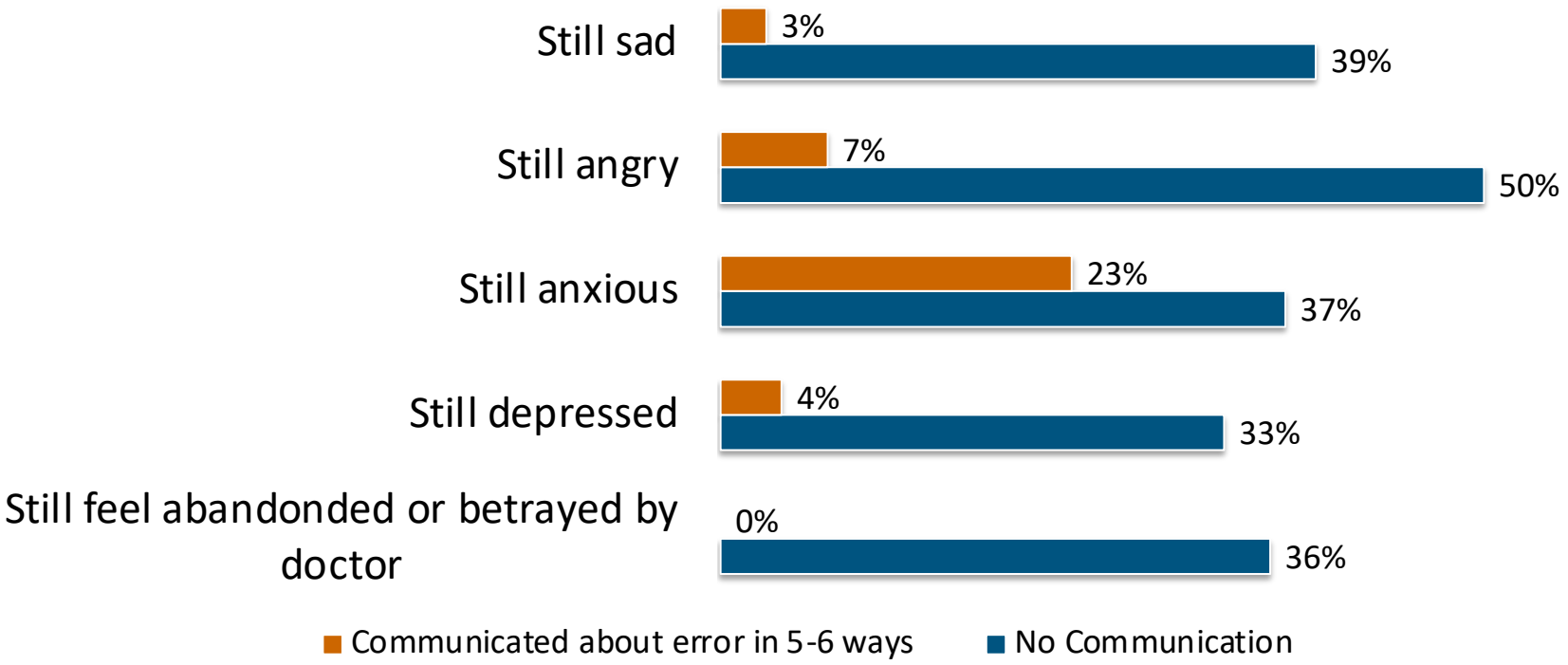


# **Openness of communication** by the care team varies after an error

***Did anyone on the care team*** **… acknowledge the error, speak openly/truthfully/in understandable way about the error, give a chance to ask questions or express feelings, offer information about the health consequences of the error?**



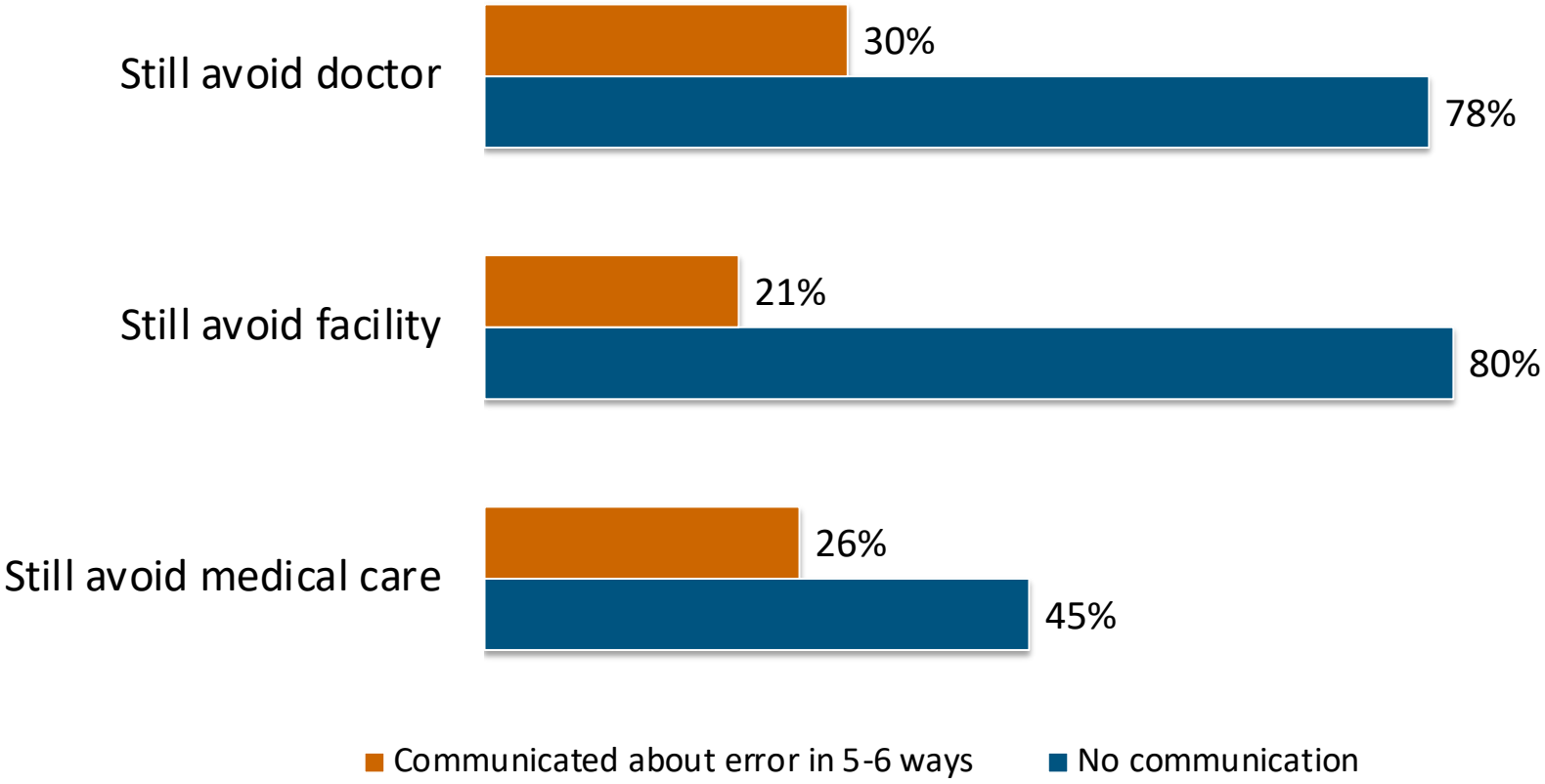
# When providers communicate openly, **emotional harm** is alleviated




*"And he even came in and apologized to me. And I've never had a doctor do that."*

– Her bowel obstruction was missed during an emergency department visit

# Open communication also alleviates **health care avoidance**



# Implications for CRPs

*"Open communication is associated with reduced emotional impacts and decreased avoidance of doctors/facilities involved in the error. Communication and resolution programmes could facilitate transparent conversations and reduce some of the negative impacts of medical error."*


Prentice JC, Bell SK, Thomas EJ, *et al.* Association of open communication and the emotional and behavioural impact of medical error on patients and families: state-wide cross-sectional survey. *BMJ Quality & Safety* Published Online First: 20 January 2020.

# With thanks to …

BETSY LEHMAN CENTER for Patient Safety

## The Betsy Lehman Center team, including:

Julia Prentice

*Director of Research*

Kim Le

*Communications and Content Manager*

## Our research partners:

Sigall Bell, Mark Schlesinger, Eric Schneider, Eric Thomas. Saul Weingart, Joel Weissman

## For more information

www.betsylehmancenterma.gov/research

BetsyLehmanCenter@massmail.state.ma.us

ARIADNE LABS

BRIGHAM HEALTH
BRIGHAM AND WOMEN'S HOSPITAL
HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

# Metrics and Tools to Implement Communication and Resolution Programs

Evan Benjamin, MD, MS

Chief Medical Officer

Ariadne Labs

Associate Professor, Harvard Medical School and

Harvard TH Chan School of Public Health

This work has been supported by the Ullem Family Foundation and The Philadelphia Foundation.

# What is CRP?

## Following Harm: *Not Always Transparent, Not Always Learning*

February 2012

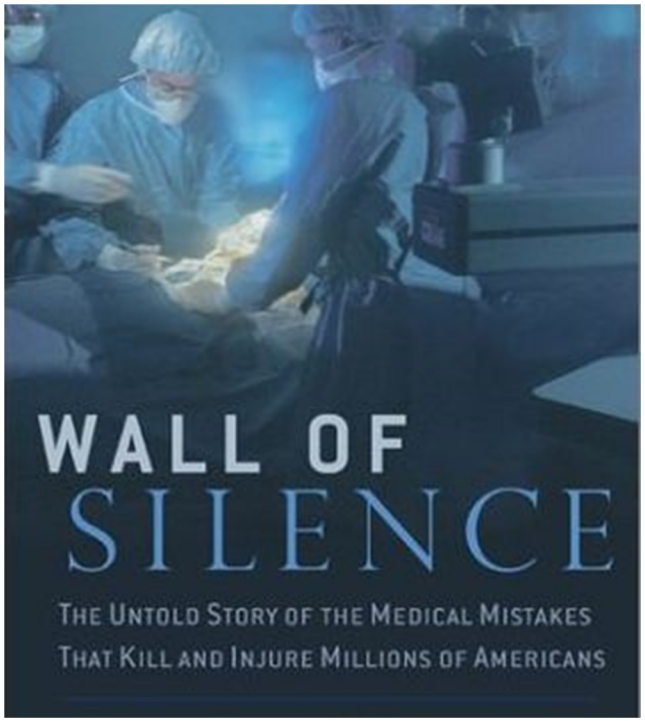
HealthAffairs

**Survey Shows That At Least Some Physicians Are Not Always Open Or Honest With Patients**

Expand

Lisa I. Iezzoni[1,*], Sowmya R. Rao[2], Catherine M. DesRoches[3], Christine Vogeli[4] and Eric G. Campbell[5]

2013




Gibson , Rosemary & J. P. Singh, Wall of Silence, 2013.

ARIADNE LABS

# CRPs are principled, comprehensive, systematic programs for preventing and responding to adverse events

| | Traditional Response | CRP Response |
|---|---|---|
| Incident reporting by clinicians | Delayed, often absent | Immediate |
| Communication with patient, family | Deny/defend | Transparent, ongoing |
| Event analysis | Physician, nurse are root cause | Focus on Just Culture, system, human factors |
| Quality improvement | Provider training | Drive value through system solutions, disseminated learning |
| Financial resolution | Only if family prevails on a malpractice claim | Proactively address patient/family needs |
| Care for the caregivers | None | Offered immediately |
| Patient, family involvement | Little to none | Extensive and ongoing |

# Promoting High-Performing CRPs

CRP uptake is rising dramatically, YET

Success of field threatened by inconsistent implementation

- Use of CRP for some cases but not others
- Use of some but not all CRP elements for individual case
- Fuels skeptics' concern that CRPs are really claims management strategy cost savings strategy

# Achieving Consistent CRP Implementation

## Step 1: Deploy CRP metrics

- Rigorous CRP metrics are critical to improving adherence

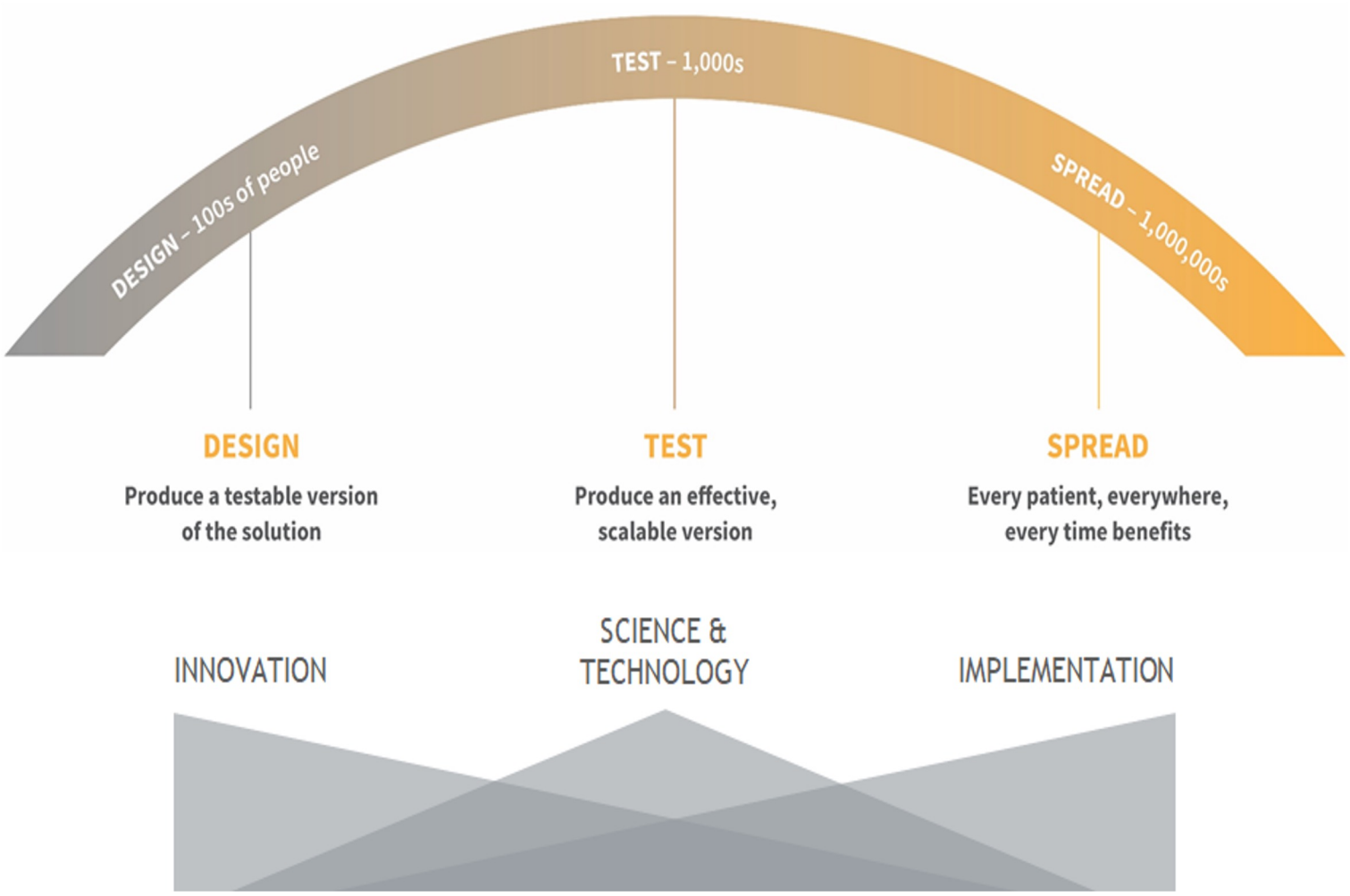
## Step 2: CRP standard work design and launch

- Training, tools, process mapping, playbook

## Step 3: Apply implementation and process improvement tools to CRP process

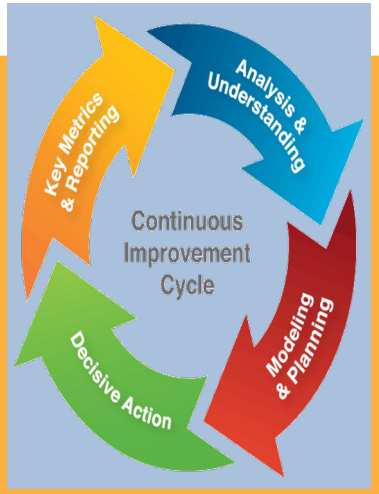
- Applying a quality improvement “systems” lens can help organizations improve their CRPs
- Importance of a roadmap/implementation and improvement guide

# Getting to Spread: The Ariadne Innovation Arc




ARIADNE LABS

# CRP Metrics: Why is Measurement Important?




Improvement

Accountability

Relevant to Patients

ARIADNE LABS

# CRP Metrics Objectives

Provide opportunity to improve implementation

Create benchmarks for success (& accountability)

Guide comprehensive, systematic CRP implementation

Facilitate ongoing reporting, transparent learning & communication

# Metrics Design: Our Process

1. Literature Review
2. Focus Groups
3. Expert Panel
4. Iteration/Rapid Cycle Feedback

# Communication-and-Resolution Metrics

| | |
|---|---|
| CRP Environment | • Culture of Safety Survey<br>• Total number of adverse events |
| CRP Steps | • Timeliness of communication with patient/family<br>• Event Analysis process<br>• Peer Support<br>• Resolution Outcome |
| Managing Serious Safety Events | • Communication<br>• System Improvement |
| CRP Outcomes | • Number of Claims<br>• Total Defense Costs<br>• Patient experience survey<br>• Provider experience survey |

ARIADNE LABS

# Pilot Testing

Focused on usability and feasibility

3 months, 5 organizations

Reporting on 10 CRP cases over a 3 month period

# Pilot Test Feedback

"The data helps to drive process for how to standardize/systematize program"

"Now we have data and ability to track outcomes, will get better as time goes on, simple process of capturing data will help them do better"

"Data collection is possible but resource intensive, considering number of events"

"Based on our data, 8/10 times we are having the communication within 24hr, so it might be more useful to know about the times when it isn't happening – for us, for now it's working pretty well"

# Domain 1: CRP Environment, numbers
# Pilot Test Results: need for standardization

**CRP Eligible Event:** Adverse event known to the organization meeting one of the following

- Harm is judged by the clinical team or institution to be (or have the potential to be) HPI SEC Level PSE 1 or higher
- Patient reports a harm event described as HPI SEC Level PSE 1 or higher
- Patient, family, or provider requests that CRP be used to respond to an event (of any severity)
- Written demand for payment or pre-litigation notice received

**CRP Actual Event:** A CRP Eligible Event in which the organization used their CRP process (in part or in whole) to respond.

**Serious Safety Event:** A deviation from generally accepted practice or process that reaches the patient and causes severe harm or death.

# Domain 1: Overall Environment
# Pilot Test Results

| | 2018 | 2019 |
|---|---|---|
| Number of all CRP Eligible Events | 178.8 | 154.0 |
| Number of CRP Actual Events | 97.0 | 76.0 |
| Number of Serious Safety Events | 51.7 | 29.4 |

ARIADNE LABS

# COMMUNICATION-AND-RESOLUTION PROGRAM PROFILE

## CRP ENVIRONMENT

### Culture of Safety

4

### CRP Adherence


## CRP STEPS

### Reporting

3

### Event Analysis

2

### Resolution

1

## MANAGING SERIOUS SAFETY EVENTS

### Communication

3

### Improvement

2

## CRP OUTCOMES

### Patient Experience

2

### Provider Experience

3

**10%** New Claims/SSEs

**6** New Claims w/o knowledge

# Spreading Methodology

## Measurement

Set of Metrics to drive comprehensive implementation

spoke with about the adverse medical event.

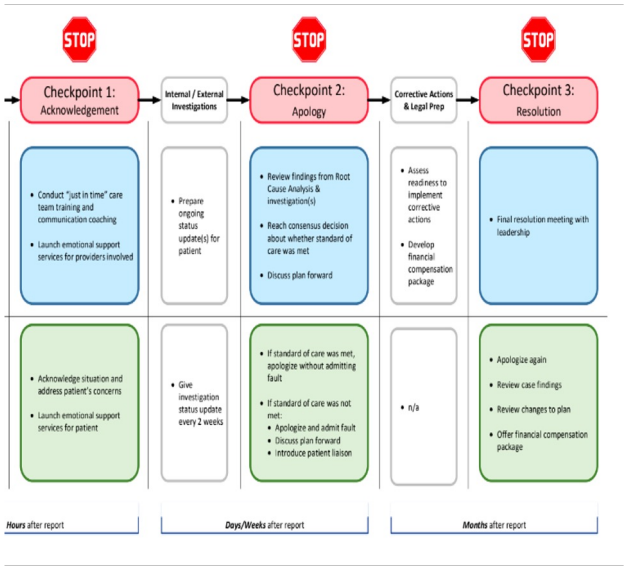
In the questions below, the word **organization** refers to the place where you or your family member or friend were receiving medical care when the adverse medical event occurred (for example, a hospital or clinic). By **provider(s)**, we mean the people who cared for you or your family member or friend at the facility (for example, doctors, physician's assistants, nurses, nurse practitioners, etc.).

The questions below ask for your opinion about the way in which the provider(s) and organization responded following the adverse medical event.

| During the process... | Strongly Disagree ▼ | Disagree ▼ | Neither ▼ | Agree ▼ | Strongly Agree ▼ |
|---|---|---|---|---|---|
| 1. I was treated with respect | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| 2. I felt that the provider(s) and organization care about what happened to me | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| 3. I felt that the provider(s) and organization were truthful with me | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| 4. I received as much information as I wanted about what happened | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| 5. I had the opportunity to talk with the right individuals about what happened | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| 5. If applicable, my perspective on what happened and how to prevent recurrences was taken into account | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| 7. If applicable, the financial compensation I was provided was fair | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

## Tools

Tools to promote standard and principled implementation approach




ARIADNE LABS

# 5 Key Tenets of CRPs: Tools


- Generate the will for change
- Mission critical language

- Immediately communicate with patient and family.
- Conversation Guides

- Share information throughout the process
- What and When guide

- Analyze and develop action plans to prevent recurrences of adverse events
- Templates

- Offer compensation in cases of substandard care
- Examples

ARIADNE LABS

# The Action Network

Institute for Healthcare Improvement

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT
*Reaching resolution after patient harm*

ARIADNE LABS

**Metrics**

With the help of measurement and patient safety experts, we have developed a robust set of metrics for organizations to assess their CRP.

**Tools**

We are developing new tools to facilitate CRP adoption such as communication conversation guides, frameworks for event response processes, and change readiness assessments.

**Digital Platform**

*Content Hosting.* Easy access to adapted resources and materials;

*Collaboration & Communication.* Cross pollination of learning and experiences; and

*Data Sharing & Feedback.* Data reporting and access dashboards to inform quality improvement.

**Learning**

*Training & Education.* Two in-person and two virtual learning sessions led by CRP experts; and

*Implementation Support.* Coaching calls in between learning session with CRP and quality improvement experts.

ARIADNE LABS

# Thank you and Join us!

Contact Us:

ariadnelabs.org

EBenjamin@ariadnelabs.org
Mlong@ariadnelabs.org

ARIADNE LABS

# CRP trends across the country

**Richard C. Boothman**
Boothman Consulting Group, LLC
*MACRMI 8th Annual CARe Virtual Forum 2020*
September 21, 2020

Boothman CONSULTING

# Continued and increasing interest, but inconsistent implementation

Boothman
CONSULTING

# Making communication and resolution programmes mission critical in healthcare organisations

Thomas H Gallagher ,[1] Richard C Boothman,[2] Leilani Schweitzer,[3] Evan M Benjamin[4]

[1]Department of Medicine, University of Washington, Seattle, Washington, USA
[2]Boothman Consulting Group, LLC, Ann Arbor, Michigan, United States
[3]The Risk Authority, Stanford Medicine, Palo Alto, CA, United States
[4]Ariadne Labs, Harvard School of Public Health and Brigham & Womens Hospital, Boston, MA, United States

Patients entrust their lives to healthcare providers. Healthcare providers, in turn, aim to promote wellness, heal what can be healed and relieve suffering, all with comfort and compassion. Yet, when patients are harmed by their healthcare, too often they experience defensiveness and disregard that actually exacerbates their suffering, adding insult to injury.[1 2] Communication and resolution programmes (CRP) can mitigate this further harm and avoid pouring salt on harm are viewed as integral to the clinical mission, not as selective claims management devices.[6] CRPs appear to improve patient and provider experiences, patient safety, and in many settings lower defence and liability costs in the short term and improve peer review and stimulate quality and safety over time.[7–10] While the claims savings often associated with a CRP are welcome, authentic CRPs focus on a more ambitious goal: fostering an

# The persistent impediment to adoption

"Decades of study and interest in CRPs seem to be resulting in increased implementation with the hope that supporting patients, families and caregivers after harm could become the norm rather than the exception.

Yet a central problem looms, and unless effective solutions are enacted, the potential of CRPs may go largely unrealized. The field is rife with inconsistent implementation, which often reflects a selective focus on claims resolution rather than a fully implemented ('authentic') CRP. . . . Authentic CRPs, in contrast, are comprehensive, systematic and principled programmes motivated by fundamental culture change which prioritises patient safety and learning. In an authentic CRP, honesty and transparency after patient harm are viewed as integral to the clinical mission, not as selective claims management devices."

Gallagher TH, Boothman RC, Schweitzer L, *et al*. *BMJ Qual Saf* 05/05/2020. doi:10.1136/ bmjqs-2020-010855
http://dx.doi.org/10.1136/bmjqs-2020-010855

Boothman CONSULTING

# Too often:

- CRP is often ***equated*** with selective, early claims resolution
- Often accompanied by restrictions in practice:
  - Not approaching injured patients ***before*** they have asserted a claim
  - Not offering compensation before patients have filed suit or demanded money
  - Not engaging patients who are not represented
  - Some have extreme contrived restrictions implemented to avoid actually doing the work
    - "We don't count cases if the complication was actually listed on the consent form the patient signed."
- There remains persistent, deeply embedded, draconian thinking and practices
  - *(In response to a strong suggestion to assist parents of a brain injured child with interim help before final settlement negotiations)*

    **"Are you suggesting that we alleviate the mother's pain? It's precisely that pain that will drive her to the negotiating table. It's the pain that will let us settle this case. We would never do THAT!"**

Boothman CONSULTING

# The key difference: the driving motivation

The underlying question asked in a financially-incented response to a malpractice claim is:

"Is this case defensible?"

*This question is asked in a litigation context and the answer is measured against litigation factors and strategies. The claims management infrastructure (insurance/defense counsel) serves a boutique function not directly answerable to the clinical mission – success is measured financially by the cost of resolution*

The question asked after an unexpected patient outcome in a CRP model is:

"Did the care meet our expectations?"

(Or, put yet another way: "Are we proud of this care?")

*This question is asked of clinicians and answered via clinical factors. The entire claims management infrastructure sees itself as a component of the clinical mission and patient safety – success is measured in a clinically-principled way as to the individual harmed and by long-term patient safety measures*

**These sometimes have very different answers . . .**
**almost always with very different consequences**

Boothman CONSULTING

## CRP Essential Operational Elements

(more involved than early claims resolution because a CRP is aimed at a larger goal: cultural accountability to drive continual improvement)

| | | |
|---|---|---|
| Notification of unintended clinical outcome | Stabilize the clinical environment, protect other patients and staff | Support the patient, listen, promise full disclosure |
| Support the caregiver, listen, promise full disclosure | Normalize honesty, rigorous investigation and review, reach clinical conclusions | Share facts conclusions openly with caregivers and patients alike, then widely |
| Be principled and accountable. Compensate where warranted, be 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 |

Boothman CONSULTING

# Safer Together

## A National Action Plan to Advance Patient Safety

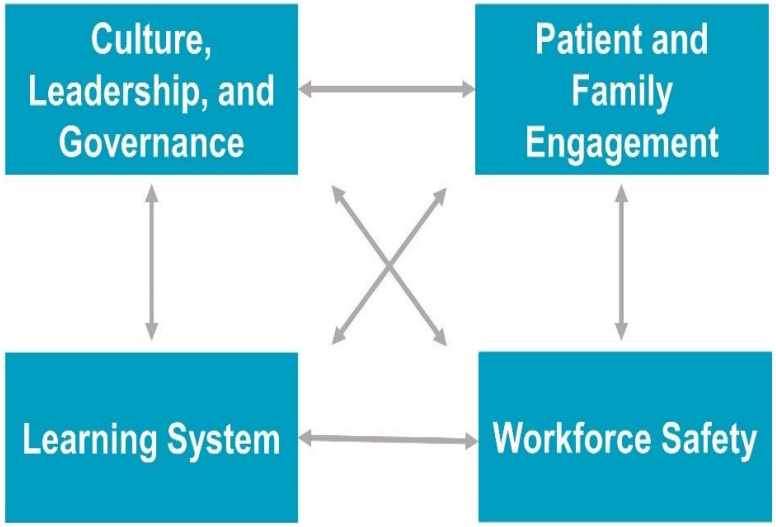
The **Institute for Healthcare Improvement** convened the **National Steering Committee for Patient Safety** as a collaboration among 27 national organizations committed to advancing patient safety.

## National Steering Committee for Patient Safety
## Working together to ensure that health care is safe, reliable, and free from harm.

- **Culture, Leadership, and Governance:** The imperative for leaders, governance bodies, and policymakers to demonstrate and foster our deeply held professional commitments to safety as a core value and promote the development of cultures of safety.
- **Patient and Family Engagement:** The spread of authentic patient and family engagement; the practice of co-designing and co-producing care with patients, families, and care partners to ensure their meaningful partnership in all aspects of care design, delivery, and operations.
- **Workforce Safety:** Ensuring the safety and resiliency of the organization and the workforce is a necessary precondition to advancing patient safety; we need to work toward a unified, total systems-based perspective and approach to eliminate harm to both patients and the workforce.
- **Learning System:** Establishing networked and continuous learning; forging learning systems within and across health care organizations at the local, regional, and national levels to encourage widespread sharing, learning, and improvement.

https://protect2.fireeye.com/url?k=74c11be7-289532cc-74c12ad8-0cc47a6d17cc-7922a332dd52095a&u=http://www.ihi.org/SafetyActionPlan

# Safer Together: A National Action Plan to Advance Patient Safety




## The Importance of Total Systems Safety

Total systems safety requires a shift from reactive, piecemeal interventions to a proactive strategy in which risks are anticipated and system-wide safety processes are established and applied across the entire health care continuum.

Boothman CONSULTING

# Self-Assessment Tool

## A National Action Plan to Advance Patient Safety

The **Institute for Healthcare Improvement** convened the **National Steering Committee for Patient Safety** as a collaboration among 27 national organizations committed to advancing patient safety.

| | SCORE: 1 | SCORE: 2 | SCORE: 3 | SCORE: 4 | ROW SCORE |
|---|---|---|---|---|---|
| **Equity** | The organization does not segment and review adverse event data and patient experience feedback by characteristics such as race, ethnicity, sexual orientation, gender, age, disability, and income. | The organization *understands the need* to segment and address adverse event data and patient experience by different patient segments and *has begun to identify the data necessary for this review*. | The organization *segments and reviews* all adverse event data and patient experience feedback by characteristics such as race, ethnicity, sexual orientation, gender, age, disability, and income. *Senior leaders regularly review identified gaps, and action plans to address health inequities are developed and executed.* | The organization segments and reviews all adverse event data and patient experience feedback by characteristics such as race, ethnicity, sexual orientation, gender, age, disability, and income. Senior leaders regularly review identified gaps, and action plans to address health inequities are developed and executed. *All leaders, clinicians, and staff receive training in health equity and unconscious bias.* | |
| **Communication and Resolution for Adverse Events** | The organization does not have a communication and resolution program (CRP) to respond to adverse events. | The organization *has made a commitment* to a communication and resolution program (CRP) to respond to adverse events, but has not made it organizational policy. | The organization *has a communication and resolution program (CRP)* to respond to adverse events. *All staff are trained in appropriate response to adverse events.* | The organization has a communication and resolution program (CRP) and a staff training plan in place to respond to adverse events. *Support programs are available for patients and families, clinicians, and staff who are impacted by these events. The program is regularly reviewed by senior leaders and the board.* | |
| **Escalation Pathways for Safety Events** | There is no mechanism for patients and families to report safety events outside of the complaint system. | *Patients have the ability to report safety events into a patient safety database*, though the system may be variable across the organization. | Patients have the ability to report safety events into a patient safety database, and there is a *structured system for patients and families to escalate concerns about their care through the use of a rapid response team or other structured response mechanism.* | Patients have the ability to report safety events into a patient safety database, and there is a structured system for patients and families to escalate concerns about their care through the use of a rapid response team or other structured response mechanism. *The organization regularly reviews and responds to safety events that have been raised by patients and families.* | |
| | | | | **TOTAL SCORE:**<br>**Patient and Family Engagement** | |

## Why is the National Action Plan's focus on health systems' transition to a CRP significant?

- Recognizes that all domains are interdependent, interconnected and interrelated
- Recognizes the link between the way in which harmed patients are treated and realizing the clinical mission
- Recognizes CRPs as the best response to unplanned outcomes because it serves both those injured in the short-term and long-term organizational interests
- No longer can any aspect of a healthcare system's professional liability response behave independent of the principles underlying the clinical mission
- Health systems' claims management infrastructure must see themselves as an integral part of their system's commitment to patient-centricity, patient safety, compassion, and the overall commitment to clinical excellence

# Other national trends potentially impacting CRPs

- Emerging interest from physician-based group practices and state medical societies
  - Not surprising: the unique motivation behind CRPs resonates quicker and deeper with caregivers than with corporations
  - Most durable transitions have occurred when clinical leaders champion the change and link it with clinical improvement initiatives and attention to clinical culture
- Alliance of Attorneys supporting CRP approaches
  - Collaborative for Accountability and Improvement (Gallagher/U of Washington)
  - Plaintiff, defense, health law, insurance and general counsel
  - Ambitious effort focused on making sure that lawyers involved in healthcare understand the broad benefits of CRPs and how they can support their clients best
  - Not naïve, some significant challenges, esp. defense counsel's role in a traditionally hourly billed practice

# Other national trends potentially impacting CRPs

- Further efforts at tort reform
  - Eviscerating tort remedies removes a major way of enforcing accountability
  - CRPs should be promoted as the healthiest and most durable way of addressing unanticipated clinical outcomes because they serve everyone's interests – cannot ever undue the harm to patients and families, but it offers the best chance at not exacerbating the injuries; as to the healthcare providers and organizations, CRPs should lead to improved culture, better communication, reduction in claims and costs, less litigation and best, improved care, evidence-based peer review and safer caregivers all of which should result in fewer malpractice claims and better care

# Consider a CRP instead of a new wave of tort reform lobbying

JAMA® Search All Enter Search Term

Review | March 24/31, 2020 Edi

New Online Views 0 | Citations 0 | Altmetric 4 | Comments

Viewpoint

September 17, 2020

More

## Another Medical Malpractice Crisis? Try Something Different

William M. Sage, MD, JD[1]; Richard C. Boothman, JD[2,3]; Thomas H. Gallagher, MD[4]

Author Affiliations | Article Information

*JAMA*. Published online September 17, 2020. doi:10.1001/jama.2020.16557

https://jamanetwork.com/journals/jama/fullarticle/2770929

Boothman CONSULTING

# Thank you

Richard C. Boothman
Boothman Consulting Group, LLC
Adjunct Assistant Professor, University of Michigan Medical School, Dept of Surgery
Visiting Scholar, Vanderbilt University Medical Center, Center for Patient and Professional Advocacy
734 645 6542
Boothman@umich.edu
Rick@Boothmanconsulting.com

# Panel 2:
# Addressing CARe Barriers

***Richard C. Boothman, JD***, Communication and Resolution pioneer and founder of Boothman Consulting, Inc.

***Pat Folcarelli***, ***RN, MA, PhD,*** Vice President of Patient Safety, CRICO (former VP of Patient Safety and Healthcare Quality, BIDMC)

***Doug Salvador, MD***, ***MPH*** Chief Quality Officer at Baystate Health

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Getting buy-in from insurers and physicians

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Don’t have the resources or the time to implement properly

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Worry about financial implications in all systems, but particularly in a for-profit system

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Difficulty in implementing in ambulatory settings

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Difficulty accessing funds for patients in immediate need before reviews are completed

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Closing Comments

Doug Salvador, MD, MPH

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

# Thank You

If you have more questions, MACRMI members are here now!

Please stay and **use the chat feature** if you have particular questions you'd like to ask.

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