Implementing Your Version of the Michigan Model
By Richard C. Boothman

Introduction

The Michigan Model works. It works on two important levels: 1. As a valuable claims management strategy and, more importantly, 2) As the ignition to a robust culture of safety. It offers a better approach to claims because it promotes early intervention on both meritorious and non-meritorious claims by asking a threshold question about unintended medical outcomes: is litigation the best response for our institution and our staff? It promotes a robust culture of safety by promoting honesty about medical errors and emphasizes, first and foremost, the importance of keeping both patients and care givers safe. The emphasis on safety importantly serves health systems' ethical obligations to both patients and their employees, but coincidentally fuels claims savings because logically, safer care leads to fewer claims.

This worksheet is designed for parties interested in adopting their own version of the Michigan Model. One size does not fit all, but there are essential components to the approach that must be present in one form or another in order for the approach to work. The following pages are intended to help identify components of the Michigan Model and prompt interested parties to think about how they can best satisfy those components in their particular health system, with the ultimate goal of creating a concrete plan for implementation that is tailored to the needs and resources of an individual health system.

Threshold Concepts

Before considering what steps and resources are important to implementing the Michigan Model, it is necessary to understand *threshold concepts* that are integral to its adoption and use:

1. **FEAR.** The medical community has bitterly complained about the adversarial climate for addressing patient injuries but for decades now, has offered no suitable alternative. Generations of health care leaders, who have known nothing else, have considered nothing else. The single most powerful factor suppressing exploration of more constructive alternatives has been fear. Fear of inviting litigation. Fear of complicating litigation. Fear of making a mistake that will lead to catastrophic claims outcomes. Like a battered person who keeps returning to their abusive environment because it's what he or she knows, we continue to rely almost exclusively on a system that doesn't serve our care givers or our institutions very well, and comes at a very high cost financially and emotionally. Overcoming the fear is key to adapting and implementing the Michigan

Model. Strategies for overcoming that fear must be consciously planned and employed or this approach will not work.

2. **ACCOUNTABILITY.**   At the heart of the Michigan Model is a totally different mindset about patient injuries. It is a mindset that says unflinchingly: We own patient injuries. Patient injuries do not represent threats to us, they represent obligations we must meet and address in a straightforward, principled way. Litigation is a tool. It is only one tool of many. And it is the tool of <u>last</u> resort, to be used when WE believe we have exhausted all applicable alternatives. We believe in most cases the decision to use litigation is ours as much, if not more than the patient's.

3. **HONESTY.** Honesty is essential to this model. Neither claims gains, nor patient safety improvements are possible without it. Litigating claims that should be resolved is costly and abusive to patients, health care givers and institutions. Denying and defending claims based on true medical errors freezes the opportunity to improve because improvement is entirely dependent on first, honestly acknowledging that a problem exists. Paying on groundless claims sends wrong signals to all concerned, encouraging patients to believe that every undesirable outcome was the result of medical error, encouraging plaintiffs' lawyers to see suits as risk-free and defense lawyers to view litigation as a source of their livelihood. The practice erodes the morale of health care givers who work in an inherently risky environment with inherently risky modalities and deserve support when they've done their best.

4. **PRINCIPLES.**   The Michigan Model is based on three simple principles:
    a. **If we have injured someone through unreasonable medical care, we will move quickly and reasonably to compensate them.**
    b. **If our care was reasonable under the circumstances or where there has been no patient injury, we owe our staff a vigorous defense (within reason).**
    c. **We must always learn from our patients' experiences.**

Leadership's Role: Backbone

These threshold concepts require some preparation before designing and implementing your institution's version of the Michigan Model. There are many strategies to combat the fear that has prevented experimentation with other models, but they all boil down to a single preparatory step: those on the front lines must be encouraged to break out of the traditional deny and defend mode to try other approaches free of fear that if the experiment doesn't work, they will not be criticized or be the subject of reprisals. In short, combating fear means that staff

working in the trenches feel free and safe to try new approaches. That translates into the need for a clear signal from leadership that new approaches should be tried and will be supported.

Such messages might include the following thoughts:

"We ask a lot of our care givers who operate in an inherently dangerous environment with inherently dangerous modalities – we know that unanticipated clinical outcomes do not necessarily mean that any of our care givers acted unreasonably. Conversely, we also know that we have room for improvement, but we cannot improve if we're unwilling to be honest about our failures or unreasonable performance. Patient safety must be the paramount concern for our institution and our staff. We will move in partnership with our patients and families to honestly evaluate every unintended outcome and act accordingly while learning from our mistakes."

"The best risk management is to not injure someone through a medical mistake. The second-best is to not repeat mistakes. We must continually strive for zero mistakes and a robust reporting system is key."

"It is the obligation of our staff to report dangerous people and dangerous practices. We want to know so we can help them and fix them."

"When a patient is injured through medical error, it is our goal to move quickly and reasonably to compensate them. It is even more important to ensure that no one else is injured."

Consider:

- What policies does your organization have? What should you have?
- Do your policies reflect an expectation that your staff will report? That they have a duty or obligation to report unsafe people and practices? That they are protected for reporting?
- Do your policies reflect the culture to which you aspire as an organization?
- Are you enforcing your policies?
- As a leader, have you provided the resources necessary to carry out the new model? Have you provided the unambiguous messages necessary to let those entrusted with your claims and risk management try this approach safely without retaliation for failure?

Who are the key personnel who should receive these messages? List them:

_____

_____

_____

3

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Component #1

Identify the close calls and unanticipated outcomes

We cannot intervene in the cycle that drives patients to lawyers if we don't know about the individual event. We cannot understand the magnitude of a clinical problem if we don't collect close calls and adverse events in aggregate to look for patterns that flag challenged processes and challenged individuals. Collecting information is critical to the model.

Health care systems have pockets of information that can and should be tapped pro-actively. Individuals all have a list in their heads of processes and people that represent a genuine, potential patient safety threat. Tapping those pockets unlocks valuable keys to improvement.

Consider:

- The staff education needed to stimulate reporting of near misses and serious adverse events?
- Where are the pockets of information? Think about non-obvious ones like billing information. How best to tap billing and coding functions as a source red flags for patient safety problems?
- Executive walk-arounds as a means of capturing close calls and challenges to safety?
- What patient safety reporting system is employed? Has it been optimized?
- What are the barriers or disincentives to reporting?
- What messages, policies, incentives can you identify to promote voluntary reporting?

List suggestions for improving reporting and tapping previously untapped sources of information at your institution:

_____

_____

_____

_____

_____

_____

_____

_____

Component #2

Distinguish between medical mistake and reasonable medical care

Health care providers work in a dangerous world with little guarantee that their interventions will have the intended effect, or worse that they won't cause harm in the process. Unanticipated outcomes do not, standing alone, signify that our care givers acted unreasonably under the circumstances. The events themselves are rarely self defining. A reliable means is necessary to evaluate those worthy of compensation and those that are unfortunate outcomes despite reasonable care.

In the end, we do our own staff no favors by defending cases that should not be defended or paying on cases in which the care was reasonable – knowing the difference is critical to the success of this model.

Consider:

- What are your resources for investigation and evaluation? List all those including your own staff, outside experts, internal reviews, etc.
- In the absence of in-house resources, can you re-deploy defense counsel in a different mode for a "blitzkrieg" evaluation to provide your organization with direction as to what are compensable vs non compensable events?
- How do you recognize unreasonable defensiveness among internal reviewers and compensate or balance that with a more objective view of the care?
- What communication or training of your reviewers is necessary to ensure an objective review? Who do you hire for this role – care givers or lawyers?
- How to invest your conclusions with institutional credibility? It is helpful to avoid keying the conclusion to any individual vs establishing a committee, for instance, that would pass on the conclusions to ensure reliability, consistency and credibility within the organization. As you create this structure, pay attention to statutory protections offered by attorney client privilege, peer review and QA protections, etc.

What is your plan for objective evaluation and conclusions about the reasonableness of care?

_____

_____

_____

_____

8

Component #3

Communication

Communication is important – effective, clear communication between all involved parties is critical to the success of this model. Communication between affected care givers and patients and families in different phases takes on different characteristics: in the acute phase following an adverse event, compassionate, careful listening is vital. Setting reasonable expectations, creating credibility with injured patients and distraught families takes some skill. The same challenges apply to communication with care givers, many of whom may also be distraught, feeling guilty, afraid of repercussions or shame. Sensitive listening, clear and compassionate communication are key to moving the adverse events to constructive grounds.

Consider:

- What training might be helpful (mediation skills, for instance) for the front line staff who will be expected to intervene in acute settings?
- Events rarely are what they appear to be at the outset – consider the training necessary to set reasonable expectations without committing your institution to a pathway before you've done good investigation?
- Providing reliable information as you collect it to patients and families builds trust and credibility – what connections will you need to create to make sure the personnel to whom the communication function is entrusted are informed of new developments like availability of autopsy results or other tests?
- How will you identify to care givers the person to whom the communication function is entrusted? And make sure they are consistently at the point for communication to ensure a consistent and controlled message to all concerned?
- One size does not fit all situations: sometimes the care giver is best to carry the communication load, other times they are the worst. Who will make that call?

Describe your plan for communicating between patients, families, involved staff:

_____

_____

_____

_____

_____

9

Component #4

Compensation

Lucian Leape, MD, the famed patient safety visionary, has said, "Apology without compensation is like taking a shower with a raincoat on. You may feel better, but you're still dirty when it's over." Compensating patients for injuries caused by medical errors is an important component to the claims management portion of this model. It not only avoids expensive and needless litigation, but also provides both patients and staff needed closure and quickly establishes critical organizational credibility that pays off in many other ways.

Knowing how much a case is worth is often incredibly difficult. Because case value is impacted by intangibles like the strength of the liability and causation elements, shock value, "cosmetic" considerations like altered records or presentation value of witnesses, pain and suffering which cannot be tabulated, economic components subject to unreasonable assumptions, etc., valuing cases is an art, not a science.

Consider:

- Even though the desire is to accomplish resolution of these cases extra-judicially, our laws and court experiences really provide much of the framework for valuing cases. What skill set do you have and need o obtain for determining fair value?
- Have you assembled a team of consultants to assist in this, including financial planners, medical economists, life care planners, mediators, lawyers?
- Institutions and care givers are at least entitled to some closure when compensation is being paid pro actively. What resources will you need to be able to prepare and present settlement agreements that contain releases, indemnification for liens, etc.? For gaining court approval in those cases that require it, like settlements of cases involving minors, incompetent patients, wrongful death?
- What mechanism do you have, or can you create that will provide for accountability, consistency, responsibility for ensuring that appropriate valuation and settlement occurs? Should you form a claims committee, for instance? If so, the membership should provide checks and balances against unreasonable decisions.

What is your plan for valuing cases and securing settlement authority:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Component #5

Learning from mistakes and patient experiences

The patient injured by medical mistake represents an immediate financial exposure to the organization; submitting *future* patients *and* your care givers to the same risk of injury is both stupid and unethical. Transparency's greatest value is the role it plays in ensuring that other patients are not harmed while you're working to adjust the claims of those who were.

Once a preventable injury occurs, whether deemed a medical mistake or not, everyone including the corporate organization, is now changed. We are no longer naïve to the risk that a patient can be injured. That new knowledge is accompanied by an obligation to take actions reasonably designed to ensure that future patients aren't similarly injured. Hardwiring your system so that knowledge of the safety risk is disseminated to those in positions to do something about it *and* to be accountable for taking steps to ameliorate the risk is extremely important. Doing so in a protected way will ensure that this becomes an organizational habit, not a risk in and of itself.

Consider:

- What statutory protections are available to protect such lessons from discovery? Design your system with those in mind.
- Even without protections, holding back lessons learned to protect the defense of a case today at the expense of causing future injuries makes no sense. There will likely be no precedent in the law for the kinds of connections you want to, or need to make. Just do it.
- How will you communicate to those in positions of authority who can make change in the fastest way possible? Communications need to be non-judgmental, factually accurate.
- How will you hold those receiving information about preventable patient injuries accountable and avoid the "institutional swirl" and hence, inertia?

Describe how you envision your organization learning from preventable mistakes?

_____

_____

_____

_____

14

Component #6

Measurement

Data drives modern medicine. It provides credibility. It enables an objective and sensible assessment of the value of this approach to your organization. It facilitates return-on-investment analyses that enable an organization to determine whether or not to devote resources to this approach, or pursue another model.

Consider:

- What measures are relevant to your organization? Relevant to determine whether the model is understood? Relevant to determining the scope of positive impact?
- Is it changing culture?
- Is it accepted by all concerned?
- What does it cost? Consider all the costs of different approaches.
- What are the savings – both tangible and intangible? Collateral benefits? Unintended costs?
- How does it compare against past performance?
- What components should you measure? Safety reports? Disclosures? The frequency with which your assessment and evaluation method is found to be accurate? Inaccurate?

What should you be measuring? List all you can think of:

_____

_____

_____

_____

_____

_____

_____

_____

_____

16

Component #7

Secure the resources

The resources needed to implement your institution's version of the Michigan Model will vary institution-to-institution and evolve over time. One can start for example, by using defense counsel in a different way, by asking them to provide a 60 day assessment from the time an adverse event is discovered and reported, not waiting until suit is brought. List all the resources you would like to work toward.

Consider:

- Do you have the right people in the roles needed to implement this model?
- What is the relative benefit of using in-house vs outside consultants?
- What mechanism will you institute to continually review and revise this evolving model?
- How will you train your human resources and monitor their progress and performance?
- Have a plan for evaluating the return-on-investment continually and annually?
- Who, within your organization, are your stakeholders? It is useful to keep your stakeholders educated about your progress and results because they will be the executives asked to pay for expansion of this program. Building credibility and an educated base of support is very helpful for future extensions.

Plan ahead. What are the future resources that would optimize this approach?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

18