Communication and Resolution: The Massachusetts Experience

Institute for Healthcare Improvement
December 13, 2017
Objectives

• Understand the merits of a CARe program and the data that supports its implementation
• Identify the elements necessary for sustaining a successful CARe program and the challenges to be aware of over time
Disclosures

• The faculty of this presentation have no disclosures.
Communication, Apology, and Resolution (CARe): The What and The Why

Evan M. Benjamin, MD, MS
CMO - Ariadne Labs
Harvard School of Public Health and Brigham & Women’s Hospital
Who We Are

MACRMI

Massachusetts Alliance for Communication and Resolution following Medical Injury
Why do patients sue?

• “Studies show that the most important factor in people’s decisions to file lawsuits is not negligence, but ineffective communication between patients and providers.”

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

Clinton & Obama, NEJM 2006
Vincent C, Lancet 1993
What’s Wrong with the Status Quo a/k/a Deny and Defend?

• **Patients** - unfair, slow, inequitable, inefficient, isolating and no apology

• **Physicians** - expensive, stressful, impacts health, modify practice and motivates defensive medicine

• **Healthcare system** - compromises patient safety, workforce and access to care and drives defensive medicine, healthcare costs and number of underinsured
Medical Liability Reform

• Tort system
  o Dysfunctional by any measure and limited ability to change
  o Reform can attenuate liability premiums
  o Minimal impact on defensive medicine

• A different system
  o A fundamental transformation
  o Fair, efficient, reliable, just and accountable
  o Supports patient safety improvement
  o Stops driving defensive medicine
  o Consistent approach to adverse events
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.
CRP History through 2012

- VA Hospital (1990s)
- 2001 University of Michigan
- 2005 MMS Engagement
- 2010 AHRQ Planning Grant/Roadmap
- 2012 Legislation MACRMI Implementation
AHRQ Planning Grant - Massachusetts

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

<table>
<thead>
<tr>
<th>Barrier</th>
<th># of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charitable immunity law</td>
<td>22</td>
</tr>
<tr>
<td>Physician discomfort with disclosure &amp; apology</td>
<td>21</td>
</tr>
<tr>
<td>Attorneys’ interest in maintaining the status quo</td>
<td>20</td>
</tr>
<tr>
<td>Coordination across insurers</td>
<td>20</td>
</tr>
<tr>
<td>NPDB or state reporting requirements</td>
<td>19</td>
</tr>
<tr>
<td>Concern about increased liability risk</td>
<td>16</td>
</tr>
<tr>
<td>Forces of inertia</td>
<td>13</td>
</tr>
<tr>
<td>Fairness to patients</td>
<td>12</td>
</tr>
<tr>
<td>May not work in other settings</td>
<td>11</td>
</tr>
<tr>
<td>Insufficient evidence</td>
<td>8</td>
</tr>
<tr>
<td>Supporting legislation</td>
<td>8</td>
</tr>
<tr>
<td>Accountability for the process</td>
<td>5</td>
</tr>
</tbody>
</table>

* Other barriers, not listed, were mentioned by <4 respondents
Roadmap: Overcoming Barriers

• Enabling Legislation - to create a supportive environment for broad adoption
• Education - programs for all involved parties
• Leadership - from all key constituencies
• Best Practices - support consistency
• Collaborative Working Groups - key issues
• Data Collection and Dissemination
Liability Reform Provisions of Ch. 224

- Six Month Pre-Litigation Resolution Period*
- Sharing all Pertinent Medical Records*
- Apology Protection - unless contradictory*
- Full Disclosure - significant complication*
- Charitable Immunity Cap Increase - 100k

Signed into law as part of Chapter 224 - Payment Reform Legislation; Effective November 5, 2012

* MMS, MATA & MBA Consensus
Transformational Change

Reactive ➔ Proactive
Adversarial ➔ Advocacy
Culture of secrecy ➔ Full disclosure / transparency
Denial ➔ Apology (healing)
Individual blame ➔ System improvement
Patient/MD isolation ➔ Supportive assistance
Fear ➔ Trust
Defensive medicine ➔ Evidence-based medicine
Conclusion - Multiple Benefits

Right and Smart thing to do

• For Patients
• For Patient Safety
• For Providers
• For Hospitals / ACOs
• For Healthcare Access and Affordability
Communication, Apology, and Resolution (CARe): Implementation and Experience

Patricia Folcarelli, RN, PhD
VP of Quality and Patient Safety – Beth Israel Deaconess Medical Center, Boston
Implementing a Program – Pre-work

- Commitment to CARe Program Best Practices and Methods by risk management, medical staff, board, and other leadership
- Commitment from your malpractice insurer
- Robust adverse event reporting, RCAs
- Just Culture
Implementation – Key Components

• 1. Educate clinicians (frequently)
• 2. Revise Risk/Safety Procedures to abide by Best Practices and Algorithms
• 3. Track cases
Educating Clinicians – Steps following an Adverse event

• **Step 1**: Report the event and get help with communication (Pager system/Reporting System/Call)

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

  A note on Apology:
  
  o 1. Statements of Regret – **Always**!
  o 2. Apology of Fault – **Once facts are known** (if applicable)
• **Step 3:** Document the communication with the patient/family in the record; facts, who was present, and results of conversation.

• **Step 4:** Check back in with the patient/family and discuss with them the findings and any systemic improvements to be made once all facts are known and root causes have been determined.
Revising Risk/Safety Procedures – CARRe Algorithms

There are two CARRe Algorithms:

- Immediate steps and a “filter” to determine whether an adverse event case should go through the full CARRe process
  - “Defining a CARRe Insurer Case”

- The full CARRe process that will be followed if a case is selected by the filter
  - “CARRe Insurer Case Protocol”
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

- Case reviewed by insurer and external experts

- CARe cases will proceed with a meeting with insurer, patient, patient’s attorney, and providers (if applicable) to formally apologize, discuss the case, and offer compensation
Non- Protocol Cases

• The majority of our cases do not meet the filter’s criteria of a CARe Insurer case (only 9% 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
## Tracking Cases

Consistency and communication are key!

<table>
<thead>
<tr>
<th>Case ID</th>
<th>Role</th>
<th>Patient Name</th>
<th>Event Date</th>
<th>Description of Event</th>
<th>Communicated to Patient/Family (Disclosure Communication)?</th>
<th>Content Status</th>
<th>Preventable? (Yes/No/Unknown)</th>
<th>Follow-up Attempted (Yes/No)</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1001</td>
<td>GW</td>
<td>Seashore, Sally</td>
<td>8/1/2015</td>
<td>Specimen misplaced</td>
<td>Yes</td>
<td>Closed</td>
<td>Yes</td>
<td>Service recovery</td>
<td>Waiting to contact patient until investigation is complete.</td>
</tr>
<tr>
<td>1002</td>
<td>JK</td>
<td>Smith, John</td>
<td>10/1/2015</td>
<td>Wrong site surgery</td>
<td>Unknown</td>
<td>Under review</td>
<td>Unknown</td>
<td>No</td>
<td>Waived procedure fees, paid per insurance.</td>
</tr>
</tbody>
</table>
Implementation Lessons Learned

• Consistency
  o Rigor in the CARe process for all adverse events is essential to the success of the program – *including* those events which were unavoidable complications.

• Leadership
  o Leadership must be on board, and continuously advocate, especially when it’s the hard thing to do

• Teamwork
  o CARe works best when risk management and patient relations communicate and work together well
Lessons Learned (Continued)

• Support
  o Providers (clinician peer support; help understanding CARe)
  o Patients (Patient Relations; MITSS; social work; help understanding CARe)

• Reinforcement
  o Re-education and reaffirming the CARe process throughout the institution helps to make a cultural change
    ▪ M&Ms, QI Directors, Grand Rounds
Design for institutions interested in implementing the CARe Program

To be used with personal assistance from our implementation team

Lays out timeline of important tasks, and links to relevant MACRMI resources for each step in the process

Implementation Guide

Institutional Preparation

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

2. Create a timeline of the implementation steps in this guide so you can realistically set a target date for official CARe launch.

3. Review the CARe policy template, modify it as appropriate for your institution, and take steps to certify this policy in your organization so that it replaces or adds to existing policies about adverse events.

4. Urge your supportive leadership to mention the program and its target implementation date at relevant meetings.

5. Work with risk management and patient safety to make sure that everyone understands the CARe philosophy and that this effort requires working together as a team to make this cultural change in the institution. Use CARe Best Practices and Best Practices for Patient Interaction.

The Daily Work

6. Map your current case review process for incidents reported internally and via a patient concern (what groups are involved in decisions about reporting, what are the escalation criteria, etc.). You can see a sample of this from one institution attached.

7. Review the CARe Procedure (for Patient Safety/Risk Staff) and accompanying documents and see how each of these steps can fit in with your current staff's workflow without much disruption. Discuss with patient safety and risk staff how these elements can best be incorporated into what they are used to doing.

8. Incorporate CARe into your case review process at every stage, including CARe in your cause mapping, so that all levels of review focus on communication to the patient, root causes, and what is being done to resolve the situation.

9. Ensure that patient safety, risk, and other health care quality leaders are prepared to coach clinicians in conversations with patients about adverse events, and that the coaching is in line
Communication, Apology, and Resolution (CARe): The Data

Allen Kachalia, MD, JD
CQO – Brigham and Women’s Hospital, Boston
Limited Data on CRPs

- While CRPs take a principled approach to dealing fairly and openly with patients, many questions persist regarding how to run them and resulting liability effects.

- Only 1 published study has shown before and after results with claims numbers and payouts when implementing a CRP.

- Data on how to implement CRPs and their liability effects could help speed CRP adoption.
Four Key Questions

1. Did the implementing hospitals stick to CARe protocol?

2. How often did CARe events require compensation offers?

3. How did CARe affect hospitals’ liability costs?

4. What lessons were learned about how to implement CRPs?
## Areas of Investigation - Massachusetts

### Data Collected

- Institution-level data on volume and costs of claims and lawsuits
- Case-specific data for each adverse event that meets study criteria
- Survey of providers involved in a CARe case
- Interviews with key personnel
- Monthly pilot site check-in calls

### Outcomes

1. **Institutional liability outcomes**
2. **Case level outcomes**
3. **Provider Satisfaction with CARe**
4. **CARe implementation experiences**
# The Massachusetts Pilot Sites

<table>
<thead>
<tr>
<th>Site</th>
<th>#Beds</th>
<th>Location</th>
<th>Teaching (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth Israel Deaconess Medical Center</td>
<td>642</td>
<td>Urban</td>
<td>Y</td>
</tr>
<tr>
<td>BID-Milton</td>
<td>88</td>
<td>Community</td>
<td>N</td>
</tr>
<tr>
<td>BID-Needham</td>
<td>58</td>
<td>Community</td>
<td>N</td>
</tr>
<tr>
<td>Baystate Medical Center</td>
<td>716</td>
<td>Urban</td>
<td>Y</td>
</tr>
<tr>
<td>Baystate Franklin Medical Center</td>
<td>93</td>
<td>Community</td>
<td>N</td>
</tr>
<tr>
<td>Baystate Mary Lane Hospital</td>
<td>31</td>
<td>Community</td>
<td>N</td>
</tr>
</tbody>
</table>
Preliminary Massachusetts Data

- Screened in: 991
- Referred to insurer: 160 (16%)
- Not referred to insurer: 821 (83%)
- Insurer status not yet determined: 10 (1%)
- 99 closed (61.9%)
- 817 closed (99.5%)
- All pending
Preliminary Conclusions

- CARe does not lead to an avalanche of new claims or require many cases to be sent to insurer
- Cases that were settled with median payment of $75K (compensation in < 5% of CARe cases)
- Most of the work of CARe is communicating about non-error events
- Based on a preliminary assessment (early after implementation), institutional liability claims and compensation cost rates did not change
Provider Satisfaction Survey

- Responses received from 182 / 270 (67%)
- Respondent demographic snapshot:
  - 78% physicians or physician trainees
  - 10% <35 years old, 31% 35-44, 35% 45-54, 24% >54
  - Top 3 clinical specialties: Surgery, Ob/Gyn, and Internal Medicine
Providers are supportive of CARRe overall

Overall, how supportive are you of using the CARRe process to resolve unanticipated outcomes? (n=108)

* 74 respondents said they did not know enough to answer this question.
Patient Feedback Study: U.S.*

40 interviews with:
- 25 patients
- 5 family members
- 10 professionals involved with CRPs (clinicians, lawyers, claims managers)

Participants recruited through CRPs

Response rate: 61%

*Study also included data from New Zealand
Patient Experience Study

• First major study to assess patients experience with a CARe-type program

• 7 major themes identified
  o Examples included:
    ▪ Ask, rather than assume, what the patient wants
    ▪ Recognize the value of lawyers
    ▪ Always communicate patient safety results

• Revamped policies, algorithms, and Best Practices to address these issues
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
Publications

• Data addressing claims numbers, provider satisfaction, and adherence published in Health Affairs earlier this month:

• Data regarding patient experience with CRPs published in JAMA earlier this month:
  • [https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2656885](https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2656885)
Communication, Apology, and Resolution (CARe):
Starting a State Collaborative

Melinda Van Niel, MBA, CPHRM
Project Manager of MACRMI – Beth Israel Deaconess Medical Center, Boston
Massachusetts Alliance for Communication and Resolution following Medical Injury

“CARe” (Communication, Apology, and Resolution) is MACRMI’s preferred way to reference the process.
Who is included

- Leadership from major hospitals/health systems who are committed to the CARe approach
- Risk management/Patient Safety team members from the above hospitals who operationalize the CARe approach on a daily basis
- Medical professional liability insurance leaders (from both commercial and captive models if both are substantial players in your region)
- Patient Advocacy and Safety leaders
- Members of the State/Regional Medical Society and/or Medical Review Board
- A leader from the local/regional Hospital Association
- Leaders in the legal community, such as well-known malpractice attorneys or leaders in a local Bar Association
- Data analysis team members (if applicable)
- Alliance Program Manager
The Work

• Develop algorithms, policies, and procedures for CARe in practice at healthcare facilities
• Determine an implementation plan to ensure that the above are put into practice, including tracking
• Develop and refine available resources for all CARe sites to a) standardize the practice of the CARe approach and b) conserve resources
• Identify difficulties in the practice of CARe and providing a safe place for discussion to work through those challenges
• Spreading the word about CARe to other local entities, particularly other healthcare facilities, and support them through their own implementation
MACRMI’s Journey

Gather Stakeholders together; secure local funding

Pilot CARe program to gather evidence

Develop website & free resources to lower barriers to entry

Educate others about CARe's merits

Change the culture in MA around the response to adverse events

2012

Today
WELCOME

MACRMI is a Massachusetts alliance of patient advocacy groups, teaching hospitals and their insurers, and statewide provider organizations committed to transparent communication, sincere apologies and fair compensation in cases of avoidable medical harm. We call this approach Communication, Apology, and Resolution (CARE) and we believe it is the right thing to do. It supports learning and improvement and leads to greater patient safety.

This site is a central resource for information on the CARE approach and the health care institutions implementing it. Here you will find answers to many of your questions regarding medical injury; resources and support for patients, families and clinicians; education and training resources for health care providers; sample guidelines and policies, research and articles, and ways to connect with each other. By sharing what we learn from medical errors and near misses, we are enhancing patient safety together and improving our health care system. Thank you for participating.
MACRMI Resources

- CARe Best Practices for institutions, attorneys, and insurers in the process
- Patient Brochure and Information Sheet
- Site Readiness Checklist
- Sample policies / procedures for implementing
- CARe FAQs for Patients, Providers and Attorneys
- Slide decks and other resources for teaching the concepts to clinicians
- CARe Algorithms
- Implementation Guide (comprehensive)
**MACRMI**

**CARe Timeline**

### Program Setup
- 24-48 hours after event (algorithm steps 1, 2)
  - Patient Safety Alarmed
  - Support services for providers and patients launched
  - Discussion with patient regarding error and known facts

### Preparation
- 2-4 weeks after event (algorithm step 3)
  - Internal investigation takes place
  - Patient Safety and Patient Relations maintain contact with providers and patients respectively

### Determination of CARe criteria fit
- 1-3 months after event (algorithm steps 4, 5)
  - 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

### Initial meeting with insurers, providers, patient safety staff, patient, counsel, and other parties
- 2-5 months after event (algorithm steps 6, 7, 8, 9)
  - 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

### Additional resolution meetings occur as necessary
- 3-6 months+ after event (algorithm steps 10, 11)
  - 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)

### Resources

- Readiness Checklist
- Implementation Team
- Implementation Guide
- Implementation Team
- Best Practices for CARe Programs
- Implementation Team
- DPH SRE Letter Templates
- Risk Managers
- Sample Communication Policy
- Risk Managers/All Staff
- Best Practices for Interfacing with Patients
- Patient Relations
- Unexpected Outcome Sheet
- Patients
- CARe Algorithms
- Risk Managers
- Insurer Referral Document (to be finished)
- Patient Relations/Risk Managers
- Best Practices for Patient Representation
- Risk Managers/Insurers
- Suggested Insurer Contact Timeline
- Insurers

### Audience
- Guidelines for Initial CARe meeting
- Risk Managers/Insurers
- Best Practices for Attorneys Representing Patients
- Attorneys
- Best Practices for Attorneys Representing Providers
- Attorneys

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Why a Statewide Collaborative

It will create:

• A community of champions who will encourage others to adopt the philosophy

• Inclusivity and understanding of the varied perspectives to be taken into account when creating useful resources

• A central location for housing resources to promote and support CARe activities and implementation throughout your region/state

• A place for learning and discussion around challenges that are faced while implementing and maintaining a CARe approach
We’re happy to help

If you’d like to get started, please view our **Guide to Starting a Statewide Collaborative** on our website: 

And give us a call!

We’re happy to help you get off the ground.
Q&A with Panelists
Appendix

Not for printing, just extra slides we might need for Q&A
What Patient Safety Improvement Ideas Has CARe Generated?

<table>
<thead>
<tr>
<th>Patient Safety Improvement</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigation findings shared with involved staff</td>
<td>36</td>
</tr>
<tr>
<td>Educational efforts</td>
<td>34</td>
</tr>
<tr>
<td>Policy changes</td>
<td>21</td>
</tr>
<tr>
<td>Safety alerts sent to staff</td>
<td>14</td>
</tr>
<tr>
<td>Input into internal QI system for ongoing analysis</td>
<td>10</td>
</tr>
<tr>
<td>New process flow diagrams created and disseminated/posted</td>
<td>10</td>
</tr>
<tr>
<td>Human factor engineering analysis</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
</tbody>
</table>

*n=114 CARe insurer cases*
Reporting Provision in State Budget

• Chapter 112 sect 5 of the General Laws is hereby amended by inserting the words: “provided, however, that payments made as part of a disclosure, apology and early offer program, shall not be construed to be reportable to or by the board against the physician, absent a determination of substandard care rendered on the part of said physician.

Proposed by MMS  Signed 7/12/13