

## Massachusetts Alliance Studies Pilot Programs in Communication, Apology and Resolution

*MACRMI hosts its first annual forum to encourage a new approach to handling adverse events in healthcare systems.*

By Melinda B. Van Niel, MBA

In July of 2012, the Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) was formed from a coalition of partners—the Massachusetts Medical Society, the Massachusetts Hospital Association, six hospital pilot sites, patient safety and advocacy organizations, and insurers—dedicated to the idea that the current medical liability system is broken and that it serves neither patients or providers well. MACRMI embarked on its mission to implement and study a Communication, Apology, and Resolution (CARE) approach to adverse events.

The CARE approach—modeled after programs at institutions like the University of Michigan Health System and Stanford Hospital and Clinics—is founded on several key tenets:

- Providers communicate with patients and families when unanticipated adverse outcomes occur.
- Adverse events are investigated, and patients are given an explanation of the findings of that investigation, including an apology or statement of regret determined by the circumstances.
- Systems improvements are implemented to avoid recurrence of the incident, thereby improving patient safety.
- In cases where an error or adverse event did not meet the standard of care and caused the patient harm, fair financial compensation and other forms of resolution are offered to the patient without having to file a lawsuit.

MACRMI believes the CARE approach to resolving adverse events proactively embodies “the right thing to do.”

Over the last nine months, MACRMI members have been working tirelessly to implement the CARE approach at

six pilot sites in Massachusetts; enact enabling legislation; educate clinicians, executives, patients, and the community at large about the merits of CARE; and, promote the approach to other institutions in the state. On April 26, 2013, MACRMI hosted its First Annual CARE Forum at the Massachusetts Medical Society in Waltham, Mass., to provide a larger audience with an in-depth look at the CARE approach. Speakers from Massachusetts and across the country came to educate the audience about CARE and programs like it. More than 130 clinicians, administrators, lawyers, and patients from around New England attended.

Dr. Alan Woodward, former president of Massachusetts Medical Society (MMS) and chair of their Committee on Liability, was first on the day’s agenda, presenting the background and accomplishments of MACRMI. Dr. Woodward spoke about research conducted in a joint effort by MMS and Beth Israel Deaconess Medical Center (BIDMC) to uncover the barriers to the CARE approach in Massachusetts and strategies for overcoming those barriers. Notably, that research found that according to 27 stakeholders in key medical liability constituencies, CARE was the most promising approach for improving the medical liability system for all. Dr. Woodward also described two significant accomplishments since July of 2012:

- Enabling legislation was signed into law and took effect in November of 2012.
- A resource website ([www.macrmi.info](http://www.macrmi.info)) with information and tools for patients, clinicians, and administrators was launched in January 2013.

Dr. Kenneth Sands, senior vice president of Health Care Quality at

BIDMC, then presented information about the CARE Pilot Sites, including the implementation process and the progress to date. The six pilots include BIDMC, Beth Israel Deaconess Milton, Beth Israel Deaconess Needham, Baystate Medical Center, Baystate Mary Lane, and Baystate Franklin. These hospitals began tracking CARE cases for a three-year study on December 1, 2012. Dr. Sands guided the audience through the steps these sites took to implement CARE programs, including creating new adverse event policies and algorithms, getting buy-in from leadership and on-the-ground risk managers, and educating clinicians at the sites about CARE with resources to help them communicate with patients about adverse events (including just-in-time communication coaching and other support services). Sample tools and policies are stored on the MACRMI website and are freely accessible to the public. Dr. Sands emphasized that the pilot risk management and patient safety staff’s dedication to doing the right thing has been integral to the success of the project, and that the implementation has thus far been smooth.

Next, Dr. Michelle Mello, professor of law and public health at the Harvard School of Public Health and one of the nation’s leading researchers in the field of medical liability, described the use of programs like CARE throughout the United States. There are several sites that were awarded AHRQ demonstration grants to implement CARE-type programs a few years ago. Although data collection is still ongoing, those programs have found positive anecdotal results. Dr. Mello noted that implementing these programs consistently often requires a cultural shift, and, since litigation cases have long lifespans, the approach will take time to be successful. Those



implementing the programs should expect to make a long-term investment before seeing widespread positive results.

The Forum's keynote speaker was Jeffrey Driver, chief executive officer of Stanford University Medical Network Risk Authority, LLC, and chief risk officer of Stanford University Medical Center. Stanford has been using a program similar to CARE since 2005 called the PEARL Program (Process for Early Assessment and Resolution of Loss). PEARL involves some unique components: a seven-day ideal investigatory process flow (most cases should have a decision about whether the standard of care was met and harm caused within the seven-day window); an online PEARL process request that can be launched by patients; and an independent patient advocate role for patient support and guidance in the offer-of-compensation meetings. Mr. Driver revealed a 38% reduction in overall liability costs and a 35% reduction in annual reported claims over five years. He also shared some of the lessons learned from Stanford's experience. He noted that prompt evaluation of patient concerns and appropriate intervention is critical, that education and training is an important component to PEARL success, and that early investigations pay dividends in warding off and defending claims, as well as reducing claims expenses. Mr. Driver was very supportive of the Massachusetts stakeholder alliance (mentioning that he hoped to start a simi-

lar alliance on the West Coast) and concluded by saying that he was very excited to see where MACRMI and the CARE program would be in a few years.

Since the patient's perspective is essential to developing change in health care around this work, the next presentation was that of a patient's experience. Winnie Tobin from MITSS introduced a video testimonial of a patient who had suffered an adverse event. The patient described how alone and abandoned she felt after her event, being unable to get the information she needed or obtain any reassurance from her caretakers. Her experience was very moving and highlighted the importance of keeping patients the central focus of care, continually assessing their needs, and supporting them, particularly when things go wrong. The patient ended her story by noting that if the CARE approach had been available when her event occurred, she would have felt valued as a patient and as a person. She encouraged the audience to adopt a CARE approach in the future.

Following the patient testimonial, Richard Boothman, executive director of the Office of Clinical Safety at the University of Michigan Health System, gave a summary comment of the morning's events. He discussed the cultural shift he has seen at the University of Michigan after creating the "Michigan Model," an approach similar to CARE, for over a decade. Mr. Boothman said that the staff at the University of Michigan has come

to believe that good things will happen if adverse events are reported, and they trust his office to do the right thing by them and by patients when adverse events occur. Mr. Boothman then moderated a question-and-answer panel for the audience, ending the morning session. The Forum ended with a working lunch session led by Dr. Evan Benjamin, chief quality officer for Baystate Health, on the prerequisites for implementing CARE in any Massachusetts hospital. He described a list of best practices developed by MACRMI and facilitated further discussion of the detailed steps to implement CARE from the ground up.

MACRMI's First Annual CARE Forum was an exciting and informative event. The educational goals included providing the opportunity to learn about CARE, its development, and its progress in Massachusetts; learning about similar programs throughout the country and their successes and challenges; and, most importantly, taking away concrete plans and tools on how to implement CARE. By the Second Annual Forum, MACRMI expects to have many more accomplishments and hopes that more Massachusetts healthcare facilities will be implementing CARE and experiencing its benefits.

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## Health IT Workgroup Discusses Patient Safety, Innovation, and Regulatory Efficiency

The U.S. Dept. of Health and Human Services (HHS) and Federal Communications Commission (FCC) has appointed members to serve on a new workgroup that will focus on identifying key considerations to improve patient safety and promote innovation in health information technology (health IT). The workgroup will report to the Health IT Policy Committee that advises the Office of the National Coordinator for Health IT (ONC).

The workgroup's membership includes agency officials and experts representing patients, consumers, healthcare providers, startup companies, and health plans and other third-party payers. The

workgroup also includes venture capital investors, information technology vendors, health information technology vendors, small businesses, purchasers, employers, and other stakeholders.

The Food and Drug Administration Safety and Innovation Act (FDASIA) directed the HHS Secretary, acting through the Commissioner of the U.S. Food and Drug Administration (FDA), and in consultation with ONC and the Chairman of the FCC, to develop a report that contains a proposed strategy and recommendations on an appropriate, risk-based regulatory framework for health IT, including medical mobile appli-

cations, that promotes innovation, protects patient safety, and avoids regulatory duplication. The FDA, FCC, and the HHS Office of the National Coordinator for Health IT (ONC) will review and consider the recommendations provided by the Health IT Policy Committee, based on input from the workgroup, as the three agencies write the report.

The workgroup meetings will provide opportunities for the public to comment. More information and a list of members of the workgroup are available online at <http://www.healthit.gov/policy-researchers-implementers/federal-advisory-committees-facas/fdasia>.