
# The Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI)

## 5th Annual CARe Forum
## April 13, 2017

## Handout Package

www.macrmi.info

**The Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI)**

**5th Annual CARe Forum**

**Agenda**

Thursday, April 13, 2017

Introductory Session (Sign up required)

| Time | Topic | Presenter |
|---|---|---|
| 11:00 | ***Welcome*** | Alan Woodward, MD |
| 11:05 | ***CARe & MACRMI: The History, Background, and Principles*** | Alan Woodward, MD |
| 11:30 | ***CARe Implementation: How to get a program up and running*** | Evan Benjamin, MD<br>Melinda Van Niel, MBA |
| 12:00-12:30 | ***Q&A with Presenters Above*** | |
| 12:30-1:00 | ***Bagged Lunch for participants in this session only*** | |

Main Session

| Time | Topic | Presenter |
|---|---|---|
| 1:00 | ***Welcome*** | Jim Gessner, MD |
| 1:05 | ***MACRMI and CARe: What's New***<br>*Our recent advancements, new resources, and case trace* | Melinda Van Niel, MBA |
| 1:25 | ***Massachusetts Pilot Study Research Outcomes*** | Michelle Mello, JD, PhD<br>Allen Kachalia, MD, JD |
| 2:00 | ***Q&A on Topics Above*** | Presenters above |

| | | |
|---|---|---|
| 2:15 | ***Break*** | |
| 2:30 | ***Panel 1:***<br>*CARe Insurer Cases: The First Step in Possible Compensation Cases* | Moderator: Evan Benjamin, MD |
| 3:30 | ***Panel 2:***<br>*Where CRPs can do better: A Study of Patient Participants* | Moderator: Paula Griswold |
| 4:30 | ***CRPs and the National Landscape*** | Richard Boothman, JD |
| 4:50 | ***Closing Remarks/Summary Comment*** | Alan Woodward, MD |
| 5:00 | ***End*** | |

MASSACHUSETTS MEDICAL SOCIETY

*Every physician matters, each patient counts.*

# IMPORTANT

# Conference Evaluation and CME Information

**Note: All attendees MUST check in at the registration table prior to attending this CME event.**

**Registered attendees will receive an email within 5-7 business days of this event with a link to the online evaluation for this activity. Please notify staff at the registration table if you do NOT have a valid email address.**

**Once you complete the online evaluation you will receive instructions on how to claim your CME credit and receive your certificate.**

***For questions on the evaluation or certificates, please contact MMS Customer Service at 800-843-6356 or nejmcust@mms.org.***


**MA Alliance for Communication and Resolution Following Medical Injury (MACRMI)**

**The 5th Annual Communication, Apology, Resolution Following Medical Injury**
**April 13, 2017**

Summary of Disclosure Information

None of the individuals in a position to control the content of this CME activity, and/or their spouse/partner have any relevant financial relationships with commercial interests as defined by the ACCME to disclose.

The ACCME defines a commercial interest as any entity producing, marketing, reselling, or distributing health care goods or services consumed by, or used on, patients.

# Fifth Annual CARe Forum – Speaker Biographies (in order of appearance)

## *Alan C. Woodward, MS, MD, FACEP*

Alan C. Woodward, M.D., FACEP began his practice of Emergency Medicine in Massachusetts at Newton-Wellesley Hospital in 1981. In 1989, he was recruited to Emerson Hospital to be the Chief of Emergency Medicine, a role he filled until 2007, transforming Emerson's "Emergency Room" in to a state-of-the-art Emergency Department in all respects. He has been recognized as a trailblazer for emergency medicine in Massachusetts. A committed patient advocate, he has worked tirelessly to improve access to high-quality emergency care and to enhance public health. Currently he pursues his interests in public health and health policy including liability reform and sits on numerous healthcare related boards, local and State committees, including the Massachusetts Public Health Council, the board of Tobacco Free Mass and the Massachusetts Alliance for Communication and Resolution following Medical Injury. In addition he has been active in organized medicine at the local, state and national levels. Dr. Woodward has served as president of the Massachusetts Medical Society and on the Board of Trustees for more than twenty years. Currently he is a member of the House of Delegates, the Committee on Public Health and the Committee on Professional Liability. Previously, he chaired the Committee on Legislation, and in that role after years of persistent efforts, successfully negotiated the language of Chapter 141, the comprehensive managed care Patient Bill of Rights, which passed the Massachusetts Legislature in 2000. He also served as a member of the committees on Strategic Planning, Administration and Management, and Nominations as well as task forces on Prescription Coverage, Access to Health Insurance, Hospital Closure, Conversions & Mergers, Universal Coverage and Preparedness among others.

## *Evan M. Benjamin, MD, MS, FACP*

Evan M. Benjamin, MD, MS, FACP is Professor of Medicine at Tufts University School of Medicine as well as Senior Vice President for Quality and Population Health and Chief Quality Officer, Baystate Health in Springfield, Massachusetts. Dr. Benjamin founded the Division of Healthcare Quality at Baystate in 2000 and helped to create the Center for Quality of Care Research in 2006. His work has helped to transform healthcare within the five-hospital Baystate Health system garnering a number of national awards and has been a model for other healthcare organizations. He is he is also fellowship director for the Healthcare Quality Fellowship and a co-founder of TechSpring, the Health Information Technology Innovation Center in Springfield, MA.

Nationally recognized for his work in outcomes management, and quality-of-care improvement, his publications have appeared in more than 50 articles in major journals. His research in measuring quality, patient safety and health policy has been published in the New England Journal of Medicine and JAMA. He has contributed to five books including Healthcare Quality: The Clinician's Primer (ACPE 2012).

Currently, he is on the editorial board for the American Journal of Medical Quality, and is an active reviewer for JAMA. He is an active faculty member for the Institute for Healthcare Improvement (IHI) in Cambridge, MA where he teaches improvement, change management and leadership courses. He sits on the Premier, Inc. Board Quality Committee and chairs the Premier, Inc. Strategic Clinical Advisory Committee. Dr. Benjamin speaks nationally regarding the impact of the healthcare delivery system changes on the quality and value of healthcare. He sits on a number of national policy committees and health system boards.

Dr. Benjamin received a BA in chemistry with highest honors from Williams College, Williamstown, MA; an MD from Case Western Reserve University School of Medicine in Cleveland, OH; post-graduate education in Internal Medicine at Yale-New Haven Hospital, Yale University School of Medicine, and he received a Master's in Health Policy (MHCDS) from Dartmouth College. He is married with two children and living in western Massachusetts.

## *Melinda B. Van Niel, MBA, CPHRM*

Melinda B. Van Niel, M.B.A., C.P.H.R.M., manages the Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI). She previously worked as the Manager of Patient Safety at Beth Israel Deaconess Medical Center in the department Healthcare Quality where she implemented one of the first Communication, Apology, and Resolution (CARe) programs in the state. Ms. Van Niel received her Bachelor of

Arts degree from Harvard University and her Master's in Business Administration from Villanova University with a concentration in healthcare management.

## *Allen Kachalia, MD, JD*

Allen Kachalia, MD, JD, is the Chief Quality Officer and Vice President for Quality and Safety at Brigham & Women's Hospital in Boston, Massachusetts. In this role, he oversees the institution's inpatient and ambulatory quality and safety and patient experience initiatives. Allen is a general internist and practices as an academic hospitalist on the hospital wards with medical students and residents. Allen is also Associate Professor of Medicine at Harvard Medical School and Associate Professor of Health Policy and Management at the Harvard School of Public Health where he teaches a course on legal issues in clinical medicine. His research focuses on how the law affects medical care, particularly how liability system reform and the disclosure of medical error relate to the quality and safety of healthcare.

## *Michelle Mello, JD, PhD*

Michelle Mello is Professor of Law at Stanford Law School and Professor of Health Research and Policy at Stanford University School of Medicine. She conducts empirical research into issues at the intersection of law, ethics, and health policy. She is the author of more than 150 articles and book chapters on the medical malpractice system, medical errors and patient safety, public health law, research ethics, the obesity epidemic, pharmaceuticals, and other topics. A recipient of a number of awards for her research, she was elected to the National Academy of Medicine (formerly called the Institute of Medicine) at the age of 40. From 2000 to 2014, Dr. Mello was a professor at the Harvard School of Public Health, where she directed the School's Program in Law and Public Health. In 2013-14 she was a Lab Fellow at Harvard University's Edmond J. Safra Center for Ethics. Dr. Mello teaches courses in torts and public health law. She holds a J.D. from the Yale Law School, a Ph.D. in Health Policy and Administration from the University of North Carolina at Chapel Hill, an M.Phil. from Oxford University, where she was a Marshall Scholar, and a B.A. from Stanford University.

## *Richard C. Boothman, JD*

Richard C. Boothman, JD serves as the Chief Risk Officer at the University of Michigan Health System. He is also an Assistant Professor in the Department of Surgery at the University of Michigan Medical School. For the first 21 years of his career, Rick practiced as a trial lawyer and represented doctors and hospitals in Michigan and Ohio in medical malpractice claims. In 2001, Mr. Boothman joined the University of Michigan, intent on establishing a new approach to medical malpractice. By prioritizing patient safety over traditional "deny and defend", he reasoned that both injuries and claims would drop, safety would improve and everyone in health care would be better served. His approach would come to be known as the Michigan Model. Rick and others at UMHS now actively leverage the benefits derived from the transparency for bold innovations in peer review and creative corporate reorganization to more effectively capture and respond to patient safety challenges with durable improvement. The Michigan Model approach to patient injuries has garnered national and international attention. Mr. Boothman has consulted on several research initiatives funded by the Agency for Healthcare Research and Quality's Patient Safety and Medical Liability Reform program. He sits on the Board of Directors for the National Patient Safety Foundation and the Board of Directors for the Michigan Health and Hospital Association's Keystone Center for Patient Safety & Quality. He has consulted for many academic and non-academic hospitals and health systems. Rick and others have published their experience and results in the American Health Lawyer's Journal of Health and Life Sciences Law, the Annals of Internal Medicine, Frontiers of Health Services Management, a journal of the American College of Healthcare Executives and the Milbank Quarterly. Rick has delivered scores of presentations for groups and audiences around the country.

# MACRMI Resource List

## Guides, Checklists, and Informational Content

CARe Readiness Checklist

How to Implement a CARe Program: An Implementation Guide*

Unexpected Medical Outcome: Patient Info Sheet

Informational Brochure for Patients/General Public

Starting a Statewide CARe Collaborative

A Guide to Insurer Referral Conversations*

## Tools

Sample CARe Algorithm (definition)*

Sample CARe Algorithm (protocol)

CARe Tracked Event Criteria

Tracking Spreadsheet (sample)

CARe Timeline

## Best Practices

Best Practices for CARe Programs

Best Practices for Interfacing with Patients

Best Practices for Patient Representation in CARe Programs*

Best Practices for Attorneys Representing Healthcare Providers*

Best Practices for Attorneys Representing Patients*

## Policies/Procedures/Templates

Sample CARe Procedure*

Sample Timeline for Adverse Event

Sample Communication Policy*

Sample Guidelines for CARe Meeting with Patient

DPH SRE Letter Template - 7 days*

DPH SRE Letter Template - 30 days*

Basic Introductory Powerpoint Presentation

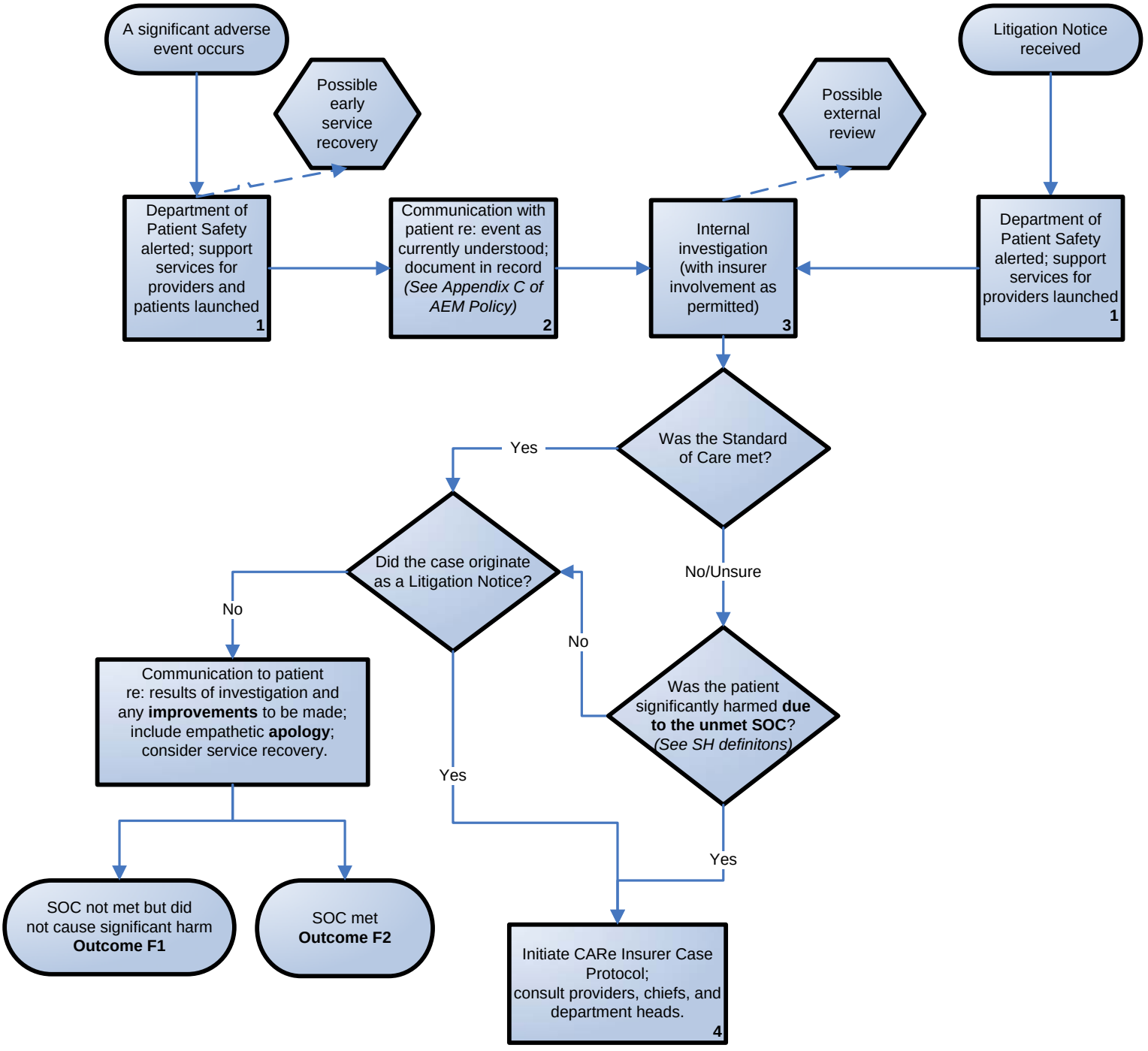
Sample Clinician Badge Card

Suggested Insurer Contact Timeline

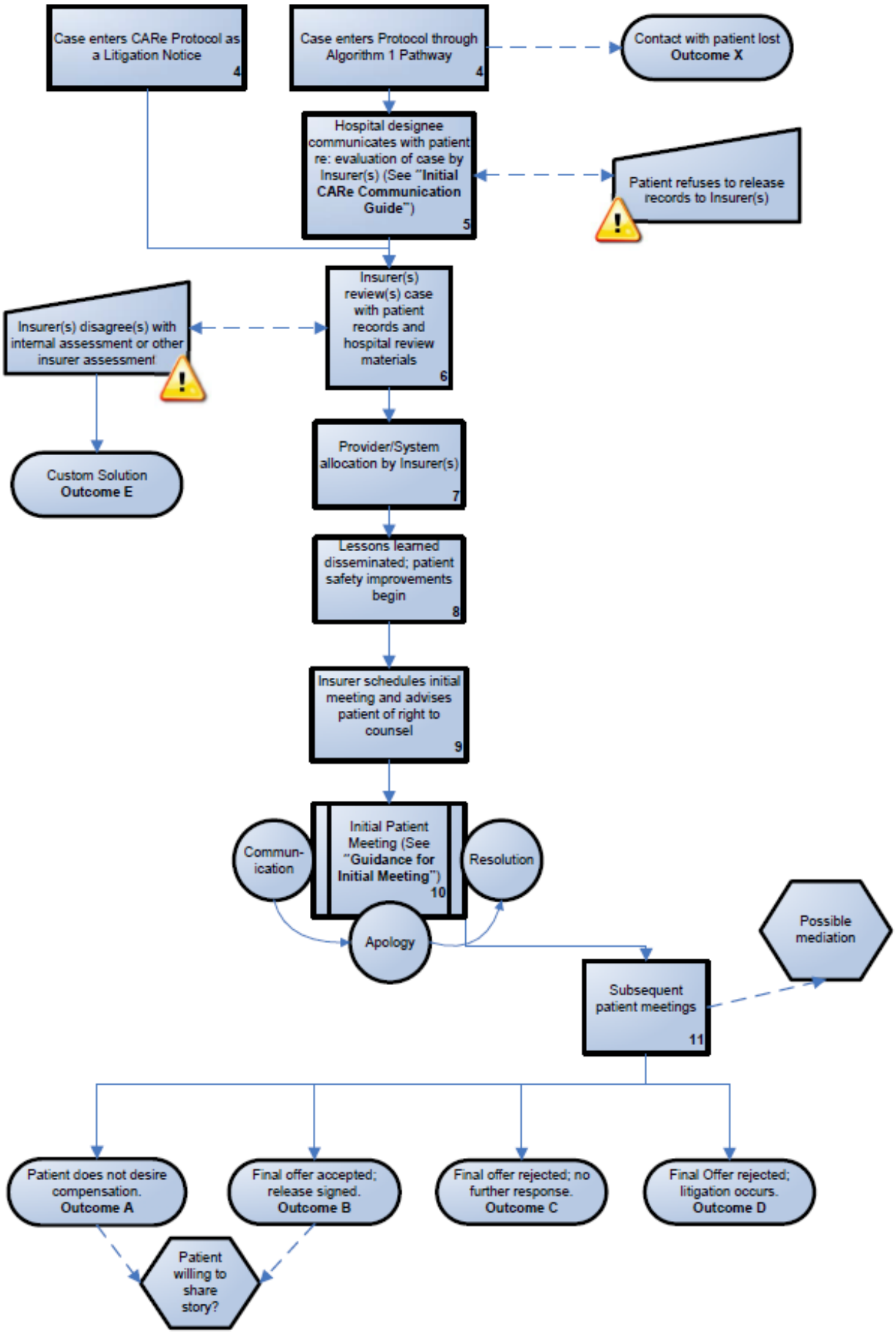
**Recently Revised*

All resources above, as well as additional articles, slides, data, and stories can all be downloaded for free on our website: www.macrmi.info (in the Resource Library tab).

# CARe Algorithm #1
# Defining a CARe Case



# CARe Algorithm #2 CARe Insurer Case Protocol



# CARe Timeline

## Program Setup

### Preparation

Ensure that the safety culture at your institution supports a CARe program

Set up resources

Educate providers

- Readiness Checklist
- Implementation Team

- Implementation Guide
- Implementation Team

- Best Practices for CARe Programs
- Implementation Team

## 24-48 hours after event

(algorithm steps 1, 2)

1

Patient Safety Alerted

Support services for providers and patients launched

Discussion with patient regarding error and known facts

- Sample Communication Policy
- Risk Managers/All Staff

- Best Practices for Interfacing with Patients
- Patient Relations

- Unexpected Outcome Sheet
- Patients

## 2-4 weeks after event

(algorithm step 3)

2

Internal investigation takes place

Patient Safety and Patient Relations maintain contact with providers and patients respectively

- DPH SRE Letter Templates
- Risk Managers

## 1-3 months after event

(algorithm steps 4, 5)

3

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

- CARe Algorithms
- Risk Managers

- Insurer Referral Document (to be finished)
- Patient Relations/Risk Managers

## 2-5 months after event

(algorithm steps 6, 7, 8, 9)

4

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

- Best Practices for Patient Representation
- Risk Managers/Insurers

- Suggested Insurer Contact Timeline
- Insurers

## 3-6 months+ after event

(algorithm steps 10, 11)

5

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)

- Guidelines for Initial CARe meeting
- Risk Managers/Insurers

- Best Practices for Attorneys Representing Patients
- Attorneys

- Best Practices for Attorneys Representing Providers
- Attorneys

Resources Audience

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Resources Audience

# MACRMI 5th Annual Forum
# Panel Participants

## *Panel 1:*

## *CARe Insurer Cases: The First Step in Possible Compensation Cases*

***Moderator:*** *Evan Benjamin, SVP, Chief Quality & Population Health Office, Baystate Health, Inc.*

***Panelists:***
*Cheryle Totte, RN, Interim Director of Patient Safety, Beth Israel Deaconess Medical Center; Debra Barbuto, RN, Patient Relations Specialist, BIDMC;*
*Allain Collins, Claims Manager, CRICO RMF;*
*Diane Thomas, Patient Relations Specialist, Baystate Medical Center;*
*Jennifer Hylemon, Claims Manager, Baystate Health, Inc.*

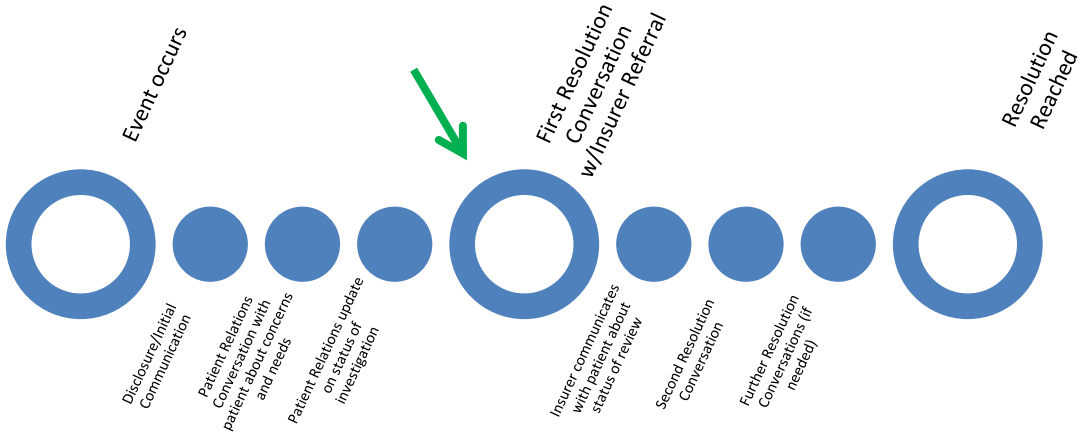
## *Panel 2:*
## *Where CRPs Can Do Better: A Study of Patient Participants*

***Moderator:*** *Paula Griswold, Executive Director of the Massachusetts Coalition for the Prevention of Medical Errors*

***Panelists:***
*Linda Kenney, Executive Director, Medically Induced Trauma Support Services;*
*Terry Ott, MLN, BA, RN, Claims Manager, Baystate Health, Inc.;*
*Pat Folcarelli, RN, PhD, Interim SVP of Quality and Safety, Beth Israel Deaconess Medical Center;*
*Jeff Catalano, JD, Partner, Todd & Weld*

## A Guide to Insurer Referral Conversations

A case is referred to an insurer in the CARe process if compensation greater than small service recovery could be warranted. Typically these are cases where the hospital's internal investigation found that 1) the care provided was unreasonable (or the team is unsure whether it was reasonable or not), *and* 2) that the care caused the patient significant harm. This referral conversation should only occur after discussion and collaboration with the insurer about the event and plan to refer patient/family to them.




Open the conversation with a sincere apology, then explain what was learned from the internal investigation and talk with the patient/family about the plan to have case reviewed by the insurer to help with resolution and make sure we are doing right by them.

**If you believe that the standard of care was not met and that caused significant harm to the patient, some suggested language for this referral conversation is below:**

*"We know that this has been a very difficult time for you, recovering from [original reason for being in hospital/practice] plus [adverse event]. We have waived all of your bills associated with your care because we do not feel that we delivered care up to our standards. We also always try to see if there is anything else we can do for you, and one of the ways we do that is by having our insurer take a look at the record of your care. This way an independent party can review the care, make sure we did not miss anything, and see if there is anything else we can offer you in order to do right by you."*

*"We realize that we should have done better in caring for you, and sincerely apologize for the injury that you suffered as a result of our care. We would like to have our insurer review your care to see if there is anything further we can do for you."*

**If you are unsure whether the care met the standard or that it caused the patient significant harm, some suggested language is below:**

*"We are sorry that this has happened and we would like to have your care reviewed by an objective outside expert to see if there is anything more that should have been done differently and that would have led to a better outcome. Our insurance company can provide that expert review if you agree that we can share your medical information with them and if you will provide them with your medical records from other medical providers. We will share the conclusions of the expert review with you."*