

The 9th Annual Communication, Apology, and Resolution Forum

Part 1

Hosted by **MACRMI** in joint providership with
the **Massachusetts Medical Society**

With special thanks to the **Coverys Community Healthcare Foundation**

Virtual Forum – October 26, 2021

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



Objective (Part 1)

- Recognize the possible biases we as healthcare workers may have, and understand ways to mitigate them

Disclosures



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

9th Annual CARE Forum

October 26, 2021

Disclosure Statement

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CME/Nursing Credit

After attending today's session you will receive a link to an evaluation (this can take up to 10 days). 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.

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
 - Recent MACRMI Activities
- Keynote Presentation: Dr. Alice Coombs
 - “Think Again! Everyone doesn’t think the same”
- Discussion session
 - with Dr. Coombs and MACRMI Co-Chairs

Communication, Apology, and Resolution (CARe)

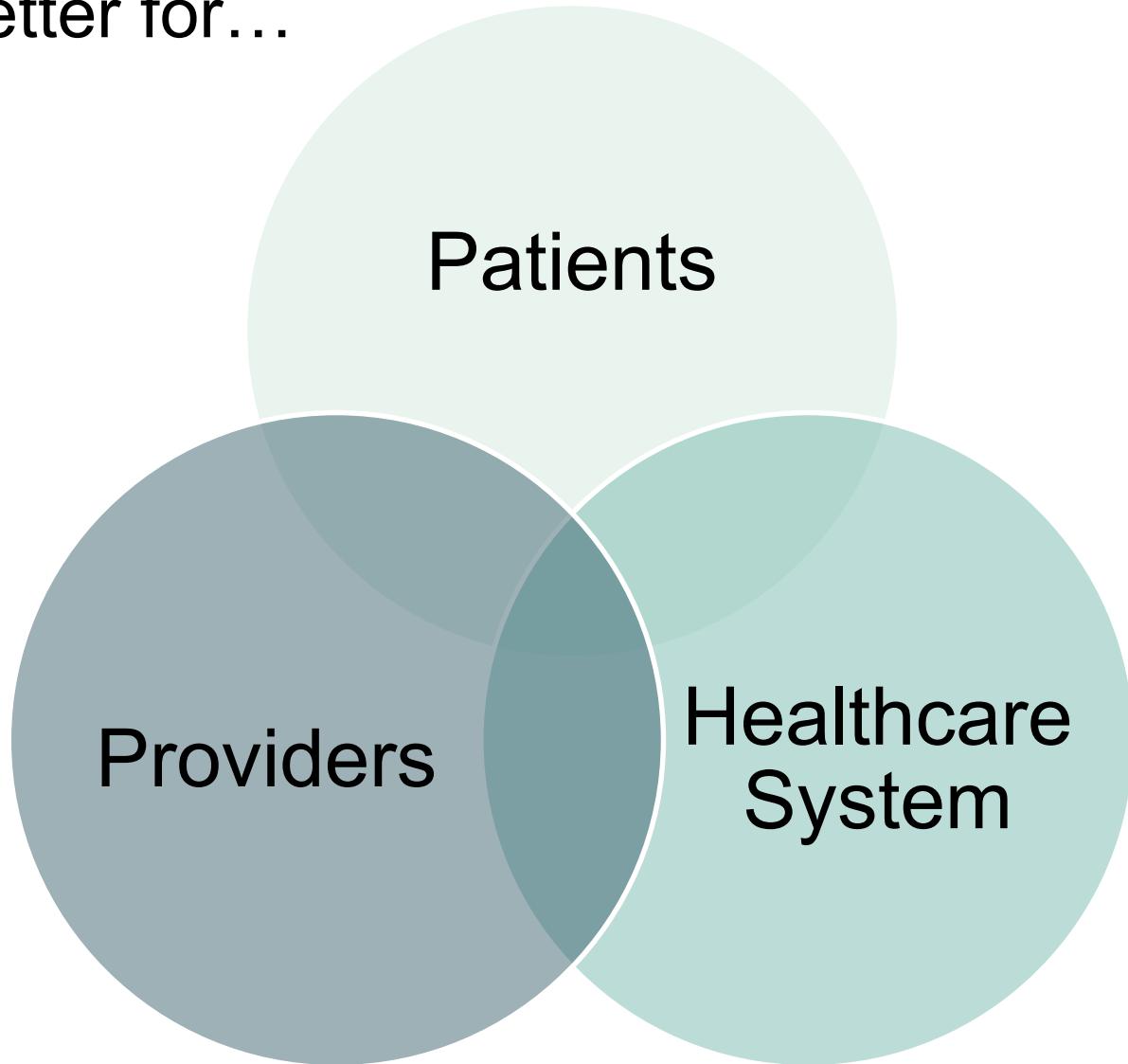
- **What is it?**
- **Why do we use it?**
- **How do we know it works?**
- **How do you get started?**

What is Communication, Apology, and Resolution (CARe)?

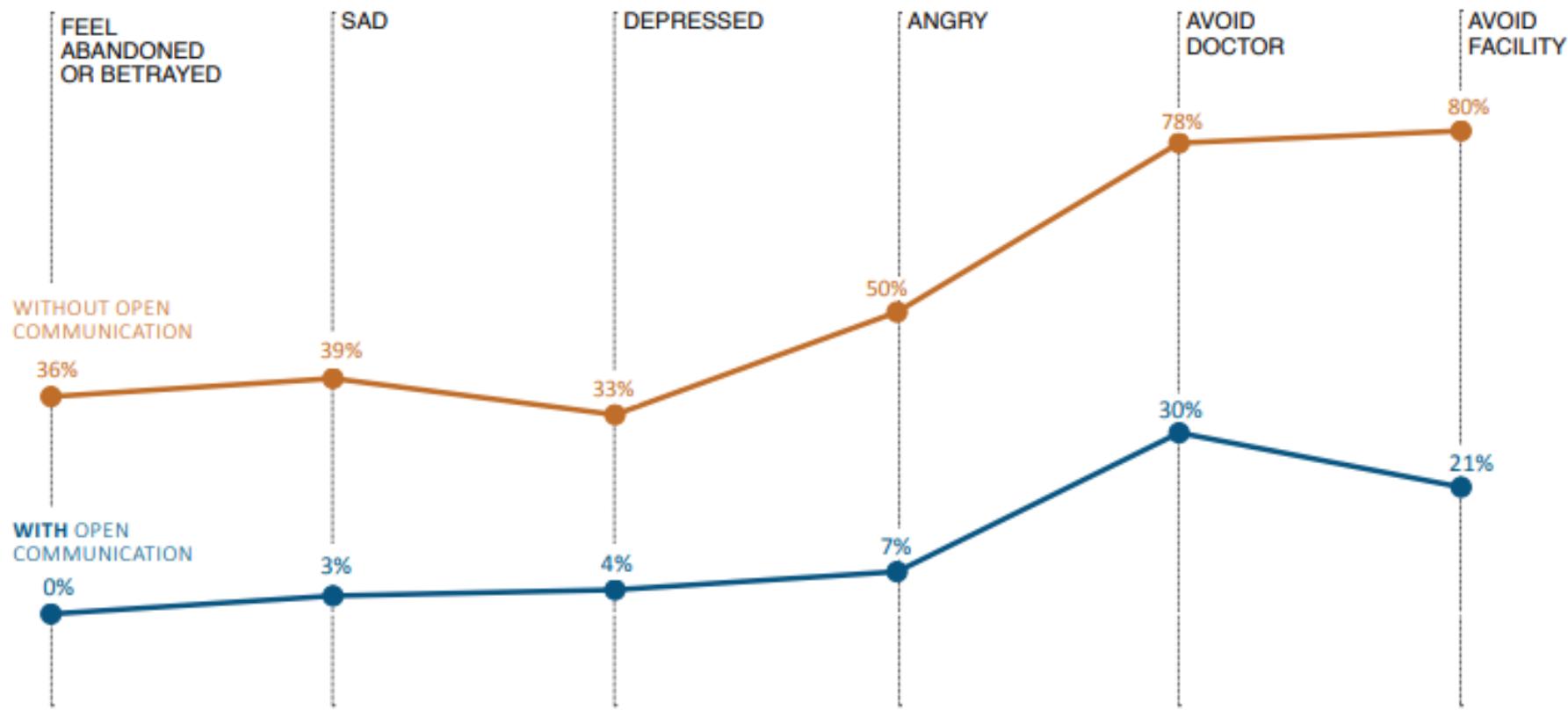
- **Communicate** with patients and families when unanticipated adverse outcomes occur, and provide for their immediate needs.
- **Investigate and explain** what happened.
- Implement systems to **avoid recurrences** of incidents and improve patient safety.
- Where appropriate, **apologize** and work towards **resolution** including an offer of fair compensation without the patient having to file a lawsuit.

Why do we use it?

It is better for...



OPEN COMMUNICATION FROM PROVIDERS IS LINKED TO LOWER LEVELS OF HARM



Data and graphic from the Betsy Lehman Center Cost of Medical Error Report – 2019-
<https://betsylehmancenterma.gov/research/costofme>

How do we know it works?

Areas of Investigation - Massachusetts

Data Collected	Outcomes
<ul style="list-style-type: none">• 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	<ol style="list-style-type: none">1. <u>Institutional liability outcomes</u>2. <u>Case level outcomes</u>3. <u>Provider Satisfaction with CARe</u>4. <u>CARe implementation experiences</u>

The Massachusetts Pilot Sites

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

Conclusions from MA Study

- **Claims did not increase** when program was used rigorously
- 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

Study-determined 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**

How do you get started?

Join us!

1. Free implementation guidance by members who have built CARe programs from the ground up
2. Free tools and resources, and assistance using them
3. Community of experienced individuals from systems of different sizes, models, and locations to discuss challenges with
4. Wider community of members involved in all aspects of medical liability to learn from and work with

MACRMI Activities and Resources

Over the last year MACRMI has...

1. Helped 7 new facilities begin CARe implementation
2. Educated Medical Staff Services staff in the state about CARe and its impact on NPDB reporting
3. Continued to educate both those in MA and around the globe about the merits of CARe
4. Developed two new resources

For Clinicians

- Clinician FAQs Document

For Safety/HCQ Staff

- Talking to Involved Providers about CARe

Website: www.macrmi.info





MACRMI

Massachusetts Alliance for Communication and Resolution following Medical Injury

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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.



For **PATIENTS**

For **PROVIDERS**

For **ATTORNEYS**

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Connect with the **MACRMI** Community

Sign-Up for Our **NEWSLETTER**