



Massachusetts Alliance for Communication  
and Resolution following Medical Injury

Massachusetts Medical Society  
March 11, 2016

# The Need: Medical Liability Reform

- Tort system (MICRA, HCs etc)
- Need a fundamentally different system  
Disclosure, Apology & Offer
  - Fair, efficient, reliable, just and accountable
  - Supports patient safety improvement
  - Reduces the fear driving defensive medicine

Massachusetts Medical Society Liability Reform  
Task Force chose DA&O in 2007

# AHRQ Planning Grant - Massachusetts

- Top five significant barriers identified
  1. Charitable immunity law
  2. Physician discomfort with disclosure & apology
  3. Attorneys' interest in maintaining status quo
  4. Coordination across insurers
  5. NPDB or state reporting requirements
- Roadmap to overcome barriers
  - Enable legislation
  - Education programs
  - Leadership
  - Best Practices
  - Collaborative working groups
  - Data collection and dissemination

# Liability Reform Provisions of Ch. 224

- 6 Month Pre-Litigation Resolution Period\*
- Sharing all Pertinent Medical Records\*
- Apology Protection - unless contradictory\*
- Full Disclosure - significant complication\*
- Pre-judgment Interest Reduction - T+2
- Charitable Immunity Cap Increase - 100k

\* MMS, MATA & MBA Consensus

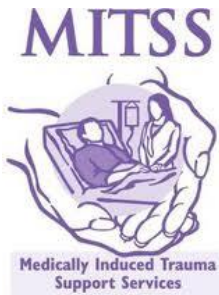
Signed into law as part of Chapter 224 - Payment Reform Legislation; Effective November 5, 2012

**BORM Reporting Language revised July 2013**

# Funding for Implementation

- Applied for AHRQ - \$3M / 3Yr Demonstration Grant
  - \$50M in ACA - no appropriation
  - Looked for alternatives locally
- Local sources of funding:
- CRICO and BHIC (malpractice insurers for pilot sites)
  - Blue Cross Blue Shield of MA, Harvard Pilgrim Health Care, Tufts Health Plan
  - Coverys, Mass Medical Society & Reliant

# Massachusetts Alliance for Communication and Resolution following Medical Injury



Massachusetts Alliance for Communication and Resolution following Medical Injury



The leading voice for hospitals.

**Massachusetts Coalition**  
for the  
**Prevention of Medical Errors**



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

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

- **Communicate** with patients and families when unanticipated adverse outcomes occur.
- **Investigate and explain** what happened.
- Implement systems to **avoid recurrences** of incidents and improve patient safety.
- Where appropriate, **apologize and offer** fair financial compensation without the patient having to file a lawsuit.

# CARe is about Communication

- The CARe program is first and foremost about communication.
- Communicating with a patient in an ongoing way when something doesn't go as expected, whether or not it was an error, is essential.
- Empathy in the communication is also important – we should always say we're sorry when there is a negative outcome for the patient. It is a human reaction and 100% encouraged!



# Principles of CARE

- Compensate patients quickly and fairly when unreasonable medical care caused injury.
- If the care was reasonable or did not adversely affect the clinical outcome, support caregivers and the organization vigorously.
- Reduce patient injuries (and therefore claims) by learning through patients' experiences.

**“Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions.” Boothman, et al; Frontiers of Health Service Management 28:3; study at the University of Michigan Health System**

# CARe Algorithms

There are two CARe Algorithms:

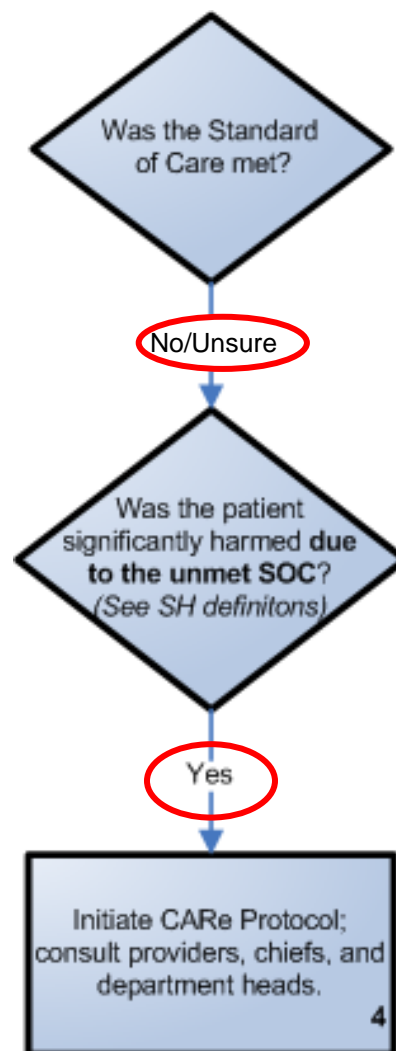
- A “filter” to determine whether an adverse event case should go through the full CARe process
  - **“Defining a CARe Case”**
- The full CARe process that will be followed if a case is selected by the filter
  - **“CARe Protocol”**

# Defining a CARE Case – the “filter”

In CARE, if a BIDMC Quality team determines that...

- The standard of care was **not** met, AND
- The unmet standard of care **caused** significant harm to the patient

...the case **moves to the Insurer for possible compensation**



# What helps CARe succeed?

- Leadership buy-in
  - Administration and Medical Staff
- Baseline culture of safety (Job #1)
  - Root cause analysis and safety improvement
  - Integration of risk management and patient relations
- Staff
  - Program manager (if large facility)
  - Commitment from risk management/patient safety
- Support
  - Clinician Peer Support
  - Patient resources
  - Larger Community of like-minded institutions

# Resources developed since May 2014

- Comprehensive CARE Implementation Guide
- Unexpected Medical Outcomes: Information for Patients
- Best Practices for Attorneys Representing Patients and Providers
- CARE Education Forum for Attorneys

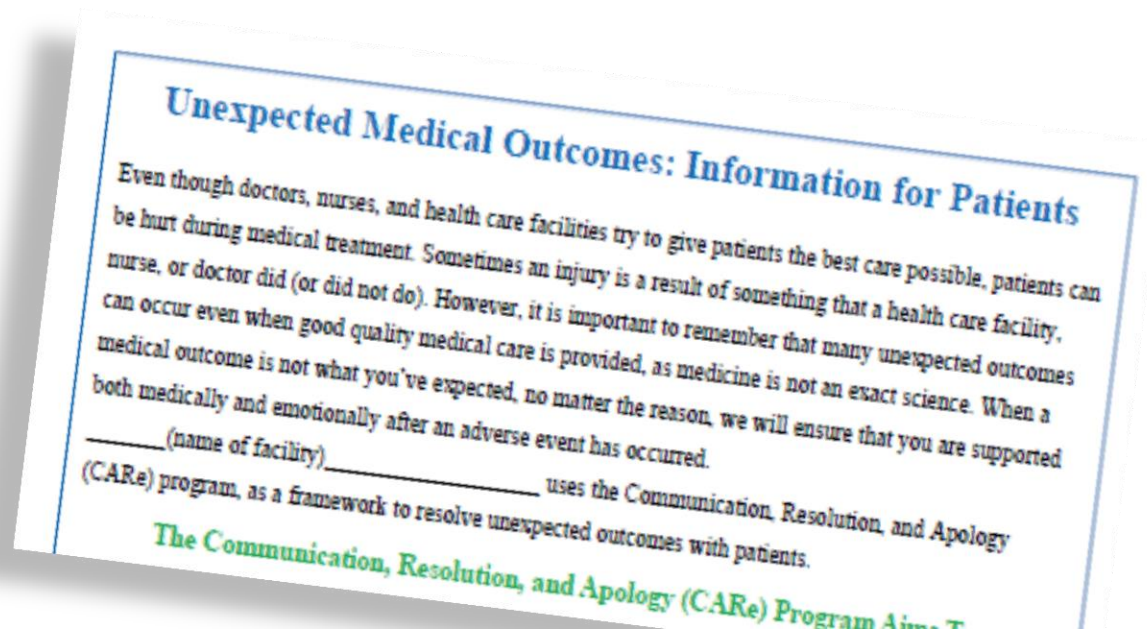
# CARe Implementation Guide

- Designed 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



# Unexpected Medical Outcomes: Information for Patients

- How can we ensure patients that have experienced an unexpected medical outcome event that the institution will support them?
- How can we inform patients about what to expect from the CARE process?



# CARe and the Legal Community

- Patients are encouraged to seek legal representation but may feel overwhelmed and unprepared to do so
- Providing attorneys with information about how the program works and understand the benefits will help resolve cases early and collaboratively



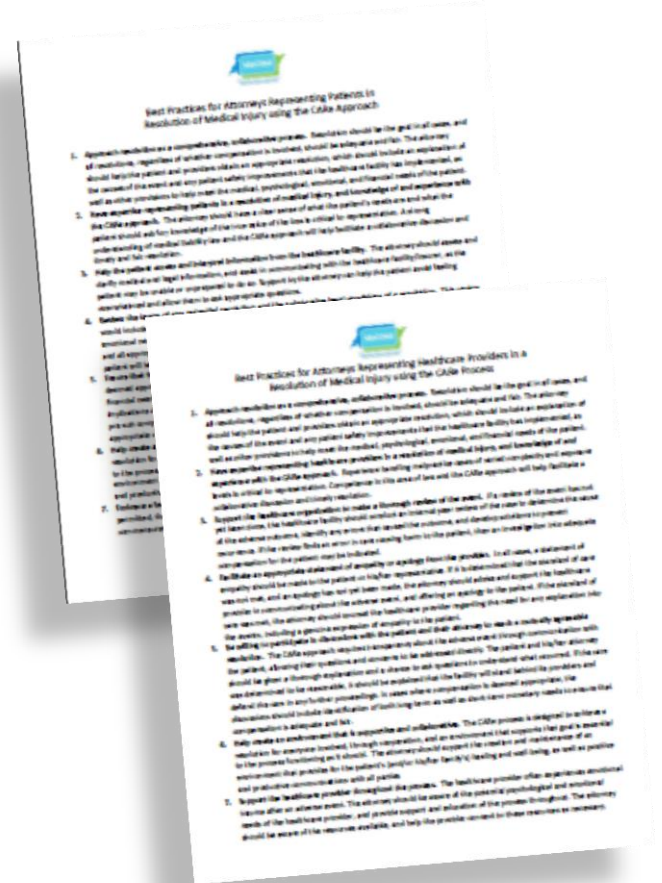
# CARe education seminar

- How can attorneys become competent in the CARe process?



# Best Practices for Attorneys Representing Patients and Providers

- How should patients be represented when they participate in the CARE process?
- How should healthcare providers be represented during the CARE process?



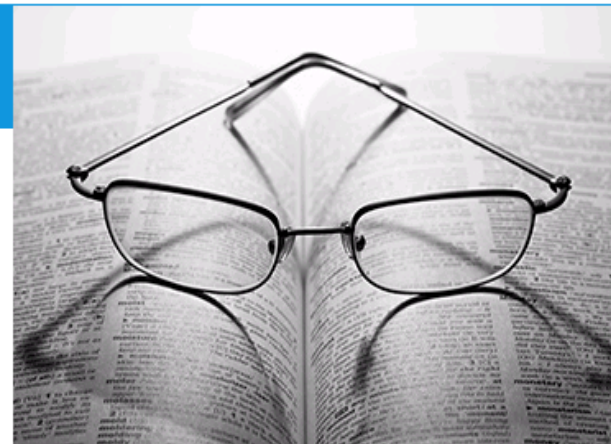
# New website section

- FAQs and useful resources, including Best Practices and a link to view the CARE education seminar at the MBA



## FAQs

- ▼ What is CARE?
- ▼ What are the advantages of CARE?
- ▼ What is evidence that it works?
- ▼ What current laws support the CARE approach?
- ▼ What is my role as an attorney representing a patient in the CARE process?
- ▼ What is my role as an attorney representing a healthcare provider in the CARE process?
- ▼ What should I expect in a CARE meeting?
- ▼ Does participating in the CARE process deny patients the right to bring legal action?



## Useful Resources

### CARE Education Forum at the Massachusetts Bar Association (MBA)

To learn more about CARE and hear from attorneys who have worked with the program, click [here](#) to register and view the webinar for free. (you must register as a non-member of the MBA when you "checkout")

### Best Practices

# All Resources Available on our Website: [www.macrmi.info](http://www.macrmi.info)



The screenshot shows the MACRMI website homepage. At the top left is the MACRMI logo, a blue and green speech bubble. To its right is the full name: "Massachusetts Alliance for Communication and Resolution following Medical Injury". Further right is a "USER LOGIN" button. Below the name is a navigation menu with links: Home, About, For Patients, For Providers, For Attorneys, Resource Library, Blog & News, and Connect. To the right of the menu are social media icons for Facebook, Twitter, and LinkedIn, with the text "Follow Us:". On the far right is a "HORIZON INTERACTIVE AWARDS BRONZE WINNER" badge and a "MARCOM AWARDS" logo. The main content area has a large blue section on the left with the heading "WELCOME" and text describing MACRMI's mission and the CARE approach. A central image shows a doctor in a white coat talking to a patient. On the right side of the main content area are five blue buttons with icons and text: "For PATIENTS" (people icon), "For PROVIDERS" (stethoscope icon), "For ATTORNEYS" (scales icon), "Use Our Resource LIBRARY" (books icon), and "Connect with the MACRMI Community" (plug icon). At the bottom right is a "Sign-Up for Our NEWSLETTER" button with a pencil icon.

**MACRMI**  
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**USER LOGIN**

**HORIZON**  
INTERACTIVE AWARDS  
BRONZE WINNER

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AWARDS

## 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 resources and support for patients, families and clinicians; and training resources for health care providers; sample communications; research and articles; and ways to connect and share what we learn from medical errors and how we are enhancing patient safety together and the health care system. Thank you for participating.

**For PATIENTS**

**For PROVIDERS**

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These resources available for download at our website