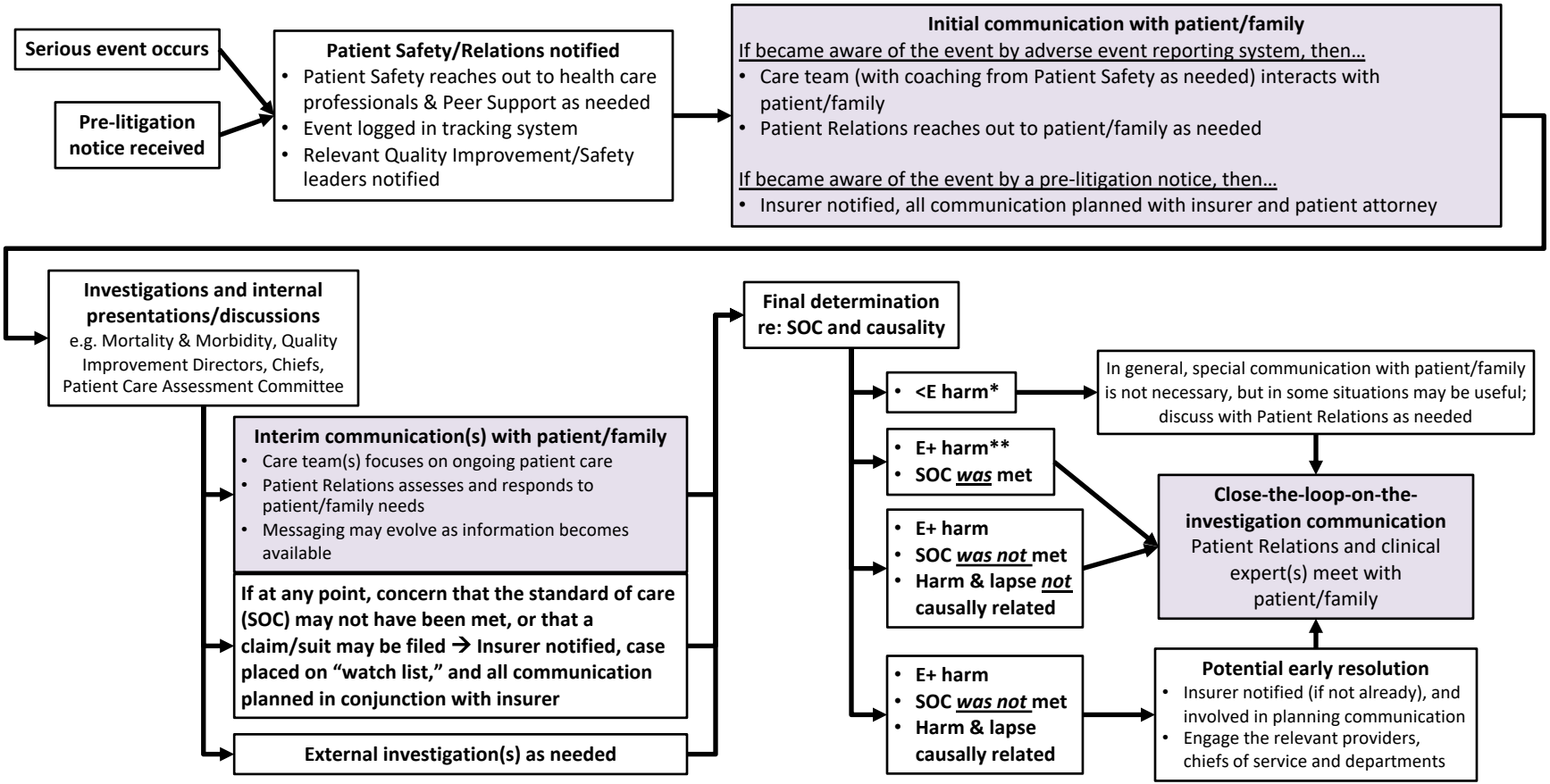
Clinician CARe Communication Algorithm



*Using NCC-MERP Scale as letter reference

**Minor temporary harm to the individual that required intervention of < 3 follow up visits and did not require an additional procedure

Initial communication

Care team (with coaching from Patient Relations as needed) interacts with patient/family

DO SAY

- *"We are so sorry this happened to you."*
- *"We're not yet sure why this happened."*
- *"We are going to do an investigation to try to figure out why this happened."*
- *"We will be in touch once we have learned more."*
- *"Right now, our primary focus is on making sure you get the care you need."*
- *"We are going to connect you with someone in patient relations who you can contact at any time. They can help you get in touch with us and get answers to other questions you may have.*

DON'T SAY

- *"We have been in touch with our Risk Manager/Insurer"*
- Don't speculate, e.g. *"We're not sure you needed that procedure" or "That other hospital didn't know what they were doing"*

Patient Relations interacts with patient/family as needed

- Express empathy and reiterate your role and contact information.
- If uncertain about whether the SOC was met, consider early service recovery, e.g. paying for parking.
- The patient/family may indicate they do not want to be contacted by Patient Relations, or they may simply not respond to outreach from Patient Relations. In the latter situation, Patient Relations should stop attempting to contact them after 2 phone calls and 1 letter asking them to reach out when ready.

Interim Communications

Care team focuses on ongoing patient care

Their communication stays focused on current state and future care, not on the adverse event. See prior tips about DOs and DON'Ts for initial communication. Direct questions about the investigation to Patient Relations.

Patient Relations interacts w/patient/family as needed

DO SAY

- *"How are you doing?"*
- *"Is there anything we can do to facilitate your care?"*
- *"We are continuing to look into why this happened."*
- *"We want to be very thorough in our investigation so we can prevent this from happening again."*
- NOTE: if there are indications that the SOC was not met, additional early service recovery may be indicated

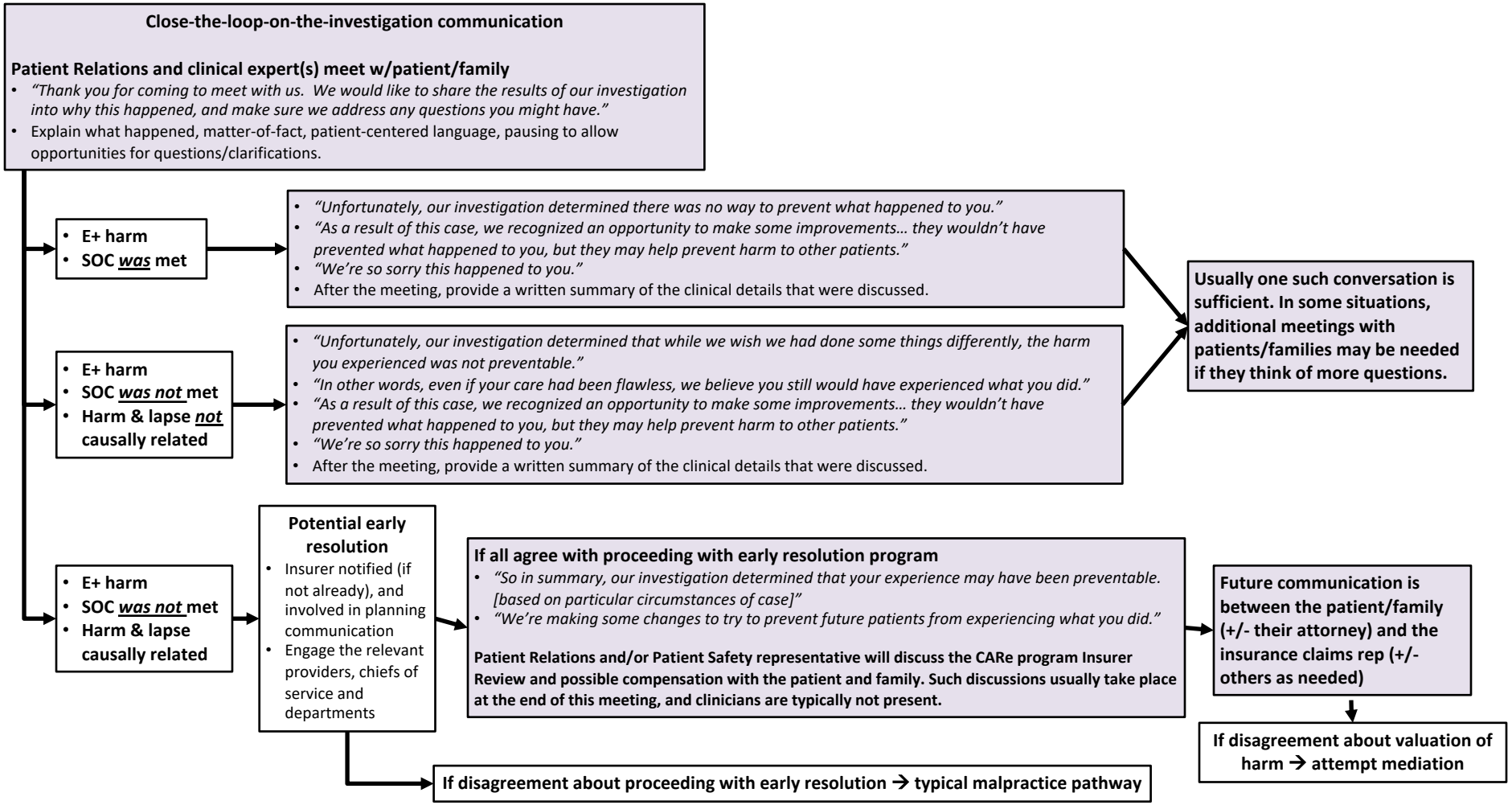
DON'T SAY

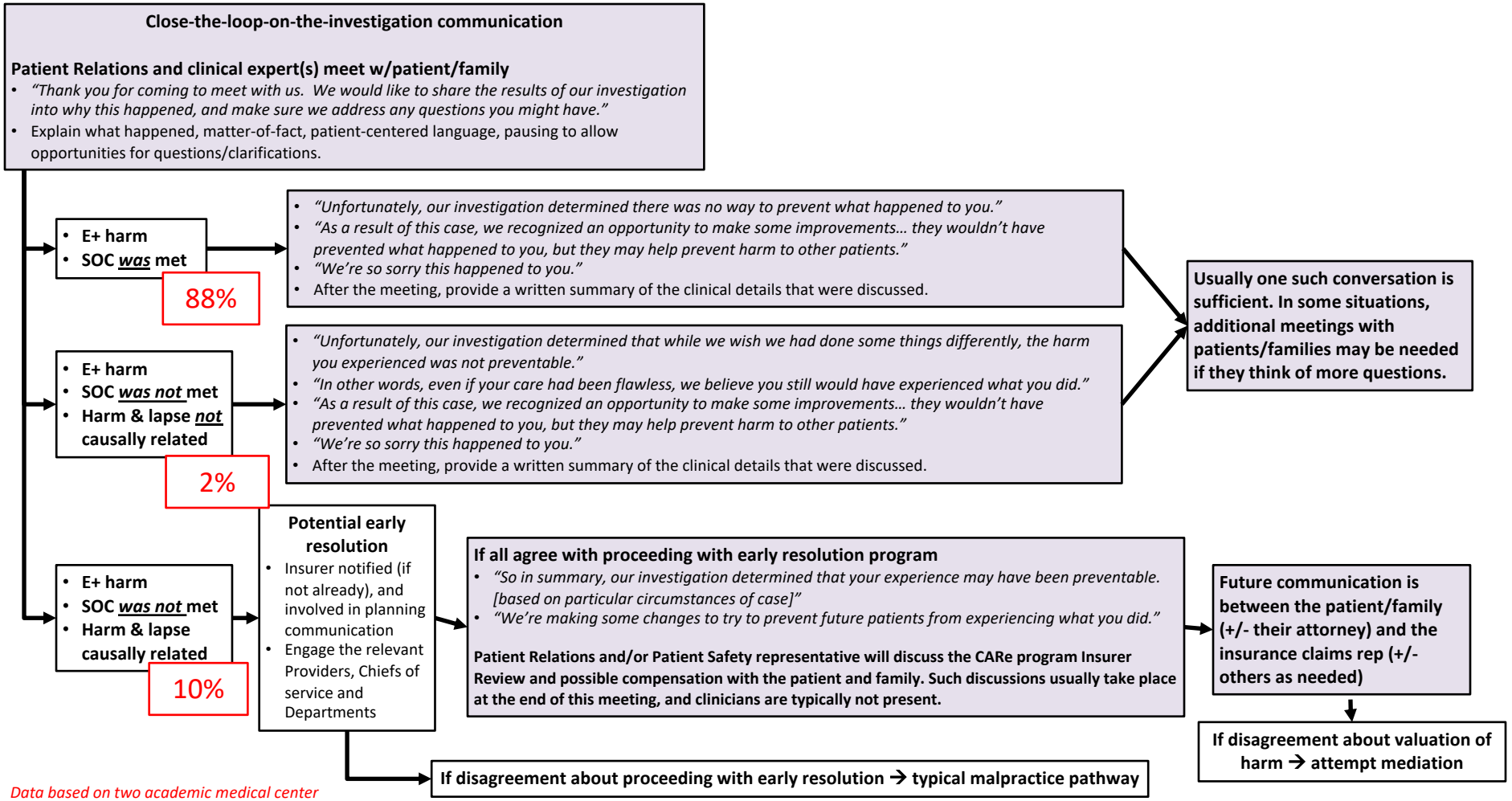
- *It takes a really long time for these cases to be reviewed.*

Situations where it is unclear whether the SOC was met, or where it's unclear if lapses in the SOC were causally related to the harm can be particularly complex, and it may take a longer time to make a final determination. In such situations:

DO SAY

- *"We want to be very thorough in our investigation so we can prevent this from happening again."*
- *"We take these events very seriously and want to give your event the time and attention it deserves. We expect to be done with the comprehensive review in about [x weeks] but I will let you know if that changes."*


Close-the-loop-on-the-investigation communication
Patient Relations and clinical expert(s) meet w/patient/family
"Thank you for coming to meet with us. We would like to share the results of our investigation into why this happened, and make sure we address any questions you might have."
Explain what happened, matter-of-fact, patient-centered language, pausing to allow opportunities for questions/clarifications.
E+ harm
SOC was met
"Unfortunately, our investigation determined there was no way to prevent what happened to you."
"As a result of this case, we recognized an opportunity to make some improvements… they wouldn't have prevented what happened to you, but they may help prevent harm to other patients."
"We're so sorry this happened to you."
After the meeting, provide a written summary of the clinical details that were discussed.
E+ harm
SOC was not met
Harm & lapse not causally related
"Unfortunately, our investigation determined that while we wish we had done some things differently, the harm you experienced was not preventable."
"In other words, even if your care had been flawless, we believe you still would have experienced what you did."
"As a result of this case, we recognized an opportunity to make some improvements… they wouldn't have prevented what happened to you, but they may help prevent harm to other patients."
"We're so sorry this happened to you."
After the meeting, provide a written summary of the clinical details that were discussed.
Usually one such conversation is sufficient. In some situations, additional meetings with patients/families may be needed if they think of more questions.
E+ harm
SOC was not met
Harm & lapse causally related
Potential early resolution
Insurer notified (if not already), and involved in planning communication
Engage the relevant providers, chiefs of service and departments
If all agree with proceeding with early resolution program
"So in summary, our investigation determined that your experience may have been preventable. [based on particular circumstances of case]"
"We're making some changes to try to prevent future patients from experiencing what you did."
Patient Relations and/or Patient Safety representative will discuss the CARe program Insurer Review and possible compensation with the patient and family. Such discussions usually take place at the end of this meeting, and clinicians are typically not present.
Future communication is between the patient/family (+/- their attorney) and the insurance claims rep (+/- others as needed)
If disagreement about valuation of harm → attempt mediation
If disagreement about proceeding with early resolution → typical malpractice pathway


Close-the-loop-on-the-investigation communication
Patient Relations and clinical expert(s) meet w/patient/family
"Thank you for coming to meet with us. We would like to share the results of our investigation into why this happened, and make sure we address any questions you might have."
Explain what happened, matter-of-fact, patient-centered language, pausing to allow opportunities for questions/clarifications.
E+ harm
SOC was met
88%
"Unfortunately, our investigation determined there was no way to prevent what happened to you."
"As a result of this case, we recognized an opportunity to make some improvements… they wouldn't have prevented what happened to you, but they may help prevent harm to other patients."
"We're so sorry this happened to you."
After the meeting, provide a written summary of the clinical details that were discussed.
E+ harm
SOC was not met
Harm & lapse not causally related
2%
"Unfortunately, our investigation determined that while we wish we had done some things differently, the harm you experienced was not preventable."
"In other words, even if your care had been flawless, we believe you still would have experienced what you did."
"As a result of this case, we recognized an opportunity to make some improvements… they wouldn't have prevented what happened to you, but they may help prevent harm to other patients."
"We're so sorry this happened to you."
After the meeting, provide a written summary of the clinical details that were discussed.
Usually one such conversation is sufficient. In some situations, additional meetings with patients/families may be needed if they think of more questions.
E+ harm
SOC was not met
Harm & lapse causally related
10%
Potential early resolution
Insurer notified (if not already), and involved in planning communication
Engage the relevant Providers, Chiefs of service and Departments
If all agree with proceeding with early resolution program
"So in summary, our investigation determined that your experience may have been preventable. [based on particular circumstances of case]"
"We're making some changes to try to prevent future patients from experiencing what you did."
Patient Relations and/or Patient Safety representative will discuss the CARe program Insurer Review and possible compensation with the patient and family. Such discussions usually take place at the end of this meeting, and clinicians are typically not present.
Future communication is between the patient/family (+/- their attorney) and the insurance claims rep (+/- others as needed)
If disagreement about valuation of harm → attempt mediation
If disagreement about proceeding with early resolution → typical malpractice pathway
Data based on two academic medical center sites over 1 year; percentages similar to data from other sites in 3-year pilot study.