BETA HEART®

Healing • Empathy • Accountability • Resolution • Trust

Section 3

HEART Event Early Resolution Process

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Definitions:

Cognitive Interview: A systematic approach to interviewing witnesses that is based on scientifically derived principles of memory retrieval and communication techniques designed to increase the amount and accuracy of information that can be obtained from an interviewee. It is useful in investigations of accidents and near-miss events. In empirical studies, the cognitive interview (CI) process has been found to produce significantly more information than standard question-and-answer type interviews. Information about the cognitive interview process is available in the Communication section of the HEART toolkit.

Early Resolution Team: Comprised of internal stakeholders and external partners who collaborate to resolve a case. The team may include executive leaders, General Counsel, internal legal, claims, and risk management representatives, clinical staff participating in collaborative case review and the peer review process, as well as BETA Healthcare Group claims and risk management staff, defense counsel, and plaintiffs' counsel.

HEART Event: Any event resulting in physical, emotional or financial harm to a patient; or, any event in which a delay in reporting or communicating with the patient or family may impede effective event review or cause more harm.

Reportable HEART Event: A HEART event where the member/insured has concerns regarding culpability or suspects that the harm may be attributable to an error or inappropriate care.

Inappropriate Care: Healthcare that is determined to have deviated from the Standard of Care.

Resolution: The act or process of resolving a problem or dispute. For purposes of BETA HEART, resolution is the process of addressing and responding to the needs of patients, families and staff who have been impacted by harm in healthcare.

Stakeholder Consensus Meeting: A meeting convened to discuss all information learned through the comprehensive event analysis. The goal of the meeting is to arrive at a consensus whether the patient was harmed by inappropriate care. The meeting takes place in anticipation of potential litigation and, provided General Counsel or a BETA claims representative participate, is protected by the attorney-client privilege. All related documentation must include a statement to the effect that the document is "Prepared in Anticipation of Litigation and Protected by the Attorney-Client Privilege." Stakeholders participating in the consensus meeting will vary according to the type of event being reviewed. Suggested participants include an executive leader, clinical content experts (medical staff, nursing, lab, etc.), Chief Medical Officer, organizational "Just Culture" leader, risk management/patient safety leader, finance representative, General Counsel, BETA claims representative.

Process:

Identification and notification of a HEART event:

1) Immediately report the adverse event to the institution's first responder (risk management, patient safety officer or designee after hours).
   a) Goal of reporting is within 60 minutes of the event's discovery so that early initial contact can be made with the patient/family.
2) Ensure that the patient's immediate clinical needs related to the risk or adverse event are addressed.
3) Ensure that the immediate needs of the involved clinicians are addressed, as it is common for clinicians involved in an event that harmed a patient to experience acute distress.
4) Engage the patient and family as soon as possible after the event's discovery by establishing priorities and expectations.
   a) Patient and family engagement include reaching out to the patient and family in an empathic manner, acknowledging what is known at the time, listening to and communicating with them about what happened, addressing how the patient's immediate needs will be managed, and what the patient can expect going forward.
5) Monitor and respond to the patient's and family's needs, questions and concerns; and share factual (as differentiated from speculative) information about the event as it becomes available.
6) Place the patient's bills on hold, pending outcome of the event analysis.

Determination of harm and event review process:

Is there evidence of patient harm due to the event, and is there an opportunity for meaningful communication, resolution and learning?

1) No:
   a) Enter event into database.
   b) Evaluate process improvement opportunities depending upon the type of near-miss or unsafe condition that has been identified.
   c) Consider awarding a "good catch" award if harm was averted through an employee's efforts.
2) Yes:
   a) Initiate contact with patient and family to acknowledge the event and inquire as to immediate needs.
      i) Refer to Policy: Communication with Patient/Family After Harm Event.
      ii) Engage patient communication consult service as needed.
      iii) Place bills for the hospital/clinic and professional fees on hold.
   b) Consider if event meets criteria as a *Reportable HEART event* and if so, complete and forward HEART Event Notification form to BETA claims representative.
   c) Consider impact to caregiver/healthcare provider.
      i) Initiate referral to peer supporter (Refer to Care for Caregiver policy).
   d) Initiate a comprehensive event analysis (which will include a process for determining what happened, whether the standard of care was met or if inappropriate care or medical error occurred, and whether inappropriate care caused any harm). This is to be distinguished from whether the care is "defensible" or not. Case review includes both collaborative case review as well as peer review, as outlined below.

Collaborative review process (internal RCA process):

Implement an internal collaborative review process that incorporates human-factors based event analysis.

1) Incorporate information from clinicians as well as patient and family perspectives.
2) Include the results of cognitive interviews.
3) Create a detailed timeline that provides all pertinent details.
   a) Were any human factors or organizational systems determined to have contributed to the event?
   b) Is the current care process optimally designed?
   c) If no system issues are identified, was the event believed to be solely due to individual reckless behavior?
   d) If due to individual behavior, seek to understand what influenced behavioral choices and decisions. With the help of cognitive interviews determine what motivated or influenced the individual to act outside of

known safe processes or in violation of procedures. This analysis should be done in the spirit of "Just Culture."

4) Once complete information is obtained, a "stakeholder consensus" meeting should be held during which a full consensus of what and why the harm occurred is arrived at (see below).
5) This information may also include whether patient/family factors contributed to the harm event.
6) All the information obtained in this section should be used for process re-design and improvement.

Peer review process:

Did individuals perform in accordance with standards?

1) Individual reviews should include all individuals who may have contributed to the harm.
2) In addition to deciding whether individuals performed in accordance with standards, there should also be a determination as to whether any inappropriate care caused harm.
3) Individual performance "issues" and their management should be handled within the departmental processes and driven by hospital policy and/or medical staff bylaws.
4) Individual peer review should also be conducted within the context of "Just Culture" principles.
5) If consensus cannot be achieved within the internal review process regarding the appropriateness of an individual's care, the case should be submitted for outside review.

Stakeholder Consensus Meeting:

A stakeholder group will convene to discuss all the information learned through the comprehensive event analysis processes. All participants should be reminded of the importance of, and maintaining, attorney client privilege and protection. Refer to definitions section for suggested participants. In the event that a non-BETA insured clinician's care is being considered for appropriateness and has potentially caused or contributed to harm, the stakeholder group will encourage appropriate representation to participate on the clinician's behalf. Evaluation will include:

1) Detailed timeline of the event including all potential system issues
2) Results of cognitive interviews
3) Stakeholder group will determine whether, in its totality (based upon all information learned), if the care provided to the patient was appropriate or not
4) If care is deemed inappropriate, assess whether the inappropriate care caused the patient's harm
5) If consensus is obtained and determined that harm was the result of inappropriate care or medical error, move to determining damages section below
6) If consensus cannot be reached on appropriateness of care or causation, then the entire case should be submitted for outside/external review
    a) BETA is available to assist with identifying potential external reviewers; consult BETA risk management or claims staff for assistance in identifying potential reviewers
7) If consensus still cannot be reached even after an external review, then the organization should confidently communicate the known facts to the patient and family in an empathic manner and answer their questions.

Determining damages and financial resolution:

If the stakeholder group determines that care was inappropriate and resulted in harm, organizational resolution team members, in collaboration with BETA claims partners, and representatives for involved clinicians not insured through BETA may engage external resources if the case indicates (examples include: life care planners, actuaries, financial planners, etc.). The team will consider the following in assessing the financial impact of the harm event on the patient/family:

1) Medical expenses (past and future)
    a) Co-pays
    b) Outstanding bills
    c) Out-of-pocket items
    d) Anticipated treatment costs
    e) Durable medical equipment
2) Wage loss (past and future)
    a) Wages lost by patient or family member

b) Lost earning capacity
c) Complete disability and inability to return to work

3) Household services (past and future)
   a) Need for hired childcare
   b) Cost of housecleaner
   c) Maintenance services
   d) Home modifications
4) General damages ("Pain and Suffering")
   a) Need for additional treatment
   b) Actual pain
   c) Prolonged healing
   d) Loss of consortium
5) All damages are subject to proof and documentation, for example:
   a) Pay stubs
   b) Invoices/bills/estimates
   c) Form W-2
   d) Tax returns
   e) Subsequent treater records
   f) Diaries/journals
   g) Lien information

Reaching resolution:

Once a determination of damages has been made, a resolution strategy should be implemented.

1) Financial resolution:
   a) If it was determined that multiple parties caused or contributed to harm, there should be a fair and reasonable apportionment of liability prior to the offering of resolution for damages. Representatives for non-BETA insured involved clinicians will be invited to participate in determining apportionment. If the parties cannot agree on apportionment where non-BETA insured clinicians are involved, the member should still proceed to attempt to resolve the matter with the patient, discounting the offer for the portion the member believes is reasonably allocable to the non-BETA insured clinician.
   b) In cases where BETA is making the payment, written consent will be obtained from the member organization or insured.
   c) Depending on the type and duration of damages, a one-time payment or periodic payments may be appropriate.
   d) An offer should be made to the patient and family that reflects a fair and reasonable evaluation of the injury. If the offer has been discounted to reflect the amount allocable to a non-BETA insured clinician, the member should explain to the patient and family that the amount offered reflects that what the member reasonably believes it is responsible for.
   e) Patients and family members should be encouraged to seek legal counsel at any time throughout the process.
   f) Not all matters may be amenable to early resolution. In general, significant injuries and substantial financial loss will be more difficult to resolve than matters that involve only limited damages. In either case, the patient and family should be advised that the amount offered has been determined to be fair and reasonable.
   g) Members are encouraged to engage BETA claims staff as a resource in any type of negotiation.
   h) If resolution is reached, a release will be obtained for all agreed upon offers of compensation. BETA claims staff are available to assist members with developing release language.
   i) If no resolution is reached, the matter may rest or become a formal claim or suit. If a claim or suit is received, it should be forwarded immediately to the BETA claims staff.
2) Non-financial resolution:
   a) Depending upon the impact to and needs of the patient and family, achieving resolution may include non-financial strategies. Opportunities for non-financial resolution will become apparent through the course of ongoing communication with the patient and family. It will be important to partner with the patient and family to determine what is most meaningful to them in bringing about resolution.

b) Examples of non-financial resolution include, but are not limited to the following:
    i) Providing a forum for patient/family to share their experience or story with medical staff and other clinicians
    ii) Patient/family representation on patient safety committees
    iii) Acknowledgement of patient harmed through naming of a lecture series in their honor

Reporting requirements:

Once resolution is achieved, the following mandatory reporting requirements should be taken into consideration.

1) Provided a resolution is reached, member should reach out to BETA claims staff for guidance on the form and language of a Release document.
2) If the patient is a minor or a dependent adult, a settlement may require approval by a court.
3) Depending on the status of the patient, there may be an obligation to notify the Centers for Medicare & Medicaid Services of a settlement.
4) Licensed providers on whose behalf a payment is made may also need to be reported to their respective licensing boards or NPDB. Note: National Practitioner Data Bank reports may not be triggered unless there is a written demand. Members should reach out to BETA claims staff for guidance.

Communicating findings to patient/family

1) Once the results of event analysis and performance improvement plans are identified, member will hold a final resolution conversation with patient and family to communicate results.
    a) Suggested participants to hold the conversation include organizational senior leaders, HEART communication resource team member, person previously designated as having primary responsibility for maintaining ongoing contact and communication with patient and family
2) In cases where inappropriate care caused harm, a proactive offer of fair financial and non-financial resolution to patient and family should be made. Offers will take place absent waiting for a request for compensation.
3) In cases where care has been deemed appropriate or the harm not to have resulted from inappropriate care, organizations may choose to provide "service recovery" on their own.
4) In all cases, open, honest, and effective communication will be provided on an ongoing basis to patients and families, including those times when care is deemed appropriate.
5) Where conflict remains regarding appropriateness of care, inappropriate care causing harm, or damages, the organization will empathically communicate confidently known facts to the patient and family, and to the extent possible, answer all questions.
6) Communication with patients and families does not conclude until the patient/family is satisfied.
7) Educate patients/families as to their right to seek legal representation at any time.

Post event dissemination of patient safety lessons learned:

1) Communication lead will meet with patient/family to communicate lessons learned and actions taken by the organization to prevent a reoccurrence.
2) De-identify cases and summarize lessons learned – share lessons throughout the organization.
3) Take steps to ensure wide distribution of lessons learned so other clinicians and institutions can prevent similar mistakes.