How to Transition a CRP Case to “Claims”

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

Learning Objectives

1. Learn practical advice from “claims professionals” on how to transition a CRP case to claims

2. Describe several of the key components for an ideal partnership and transition to claims from the perspectives of health systems, insurers, and patients and families

3. Understand the needs of patients and families, and how and when to appropriately engage them, in this transition to “claims process”

Today's Speakers

Moderator:

Barbara Pelletreau, RN, MPH
Senior Vice President, Patient Safety, CommonSpirit Health

Speaker panel:

Jack and Teresa Gentry
Patient and Family Advocates

Claire Hagan, MJ, CPHRM
Director of Risk Management Programs, Providence St. Joseph Health

Brittnie Hayes, J.D.
Claims Manager, COPIC

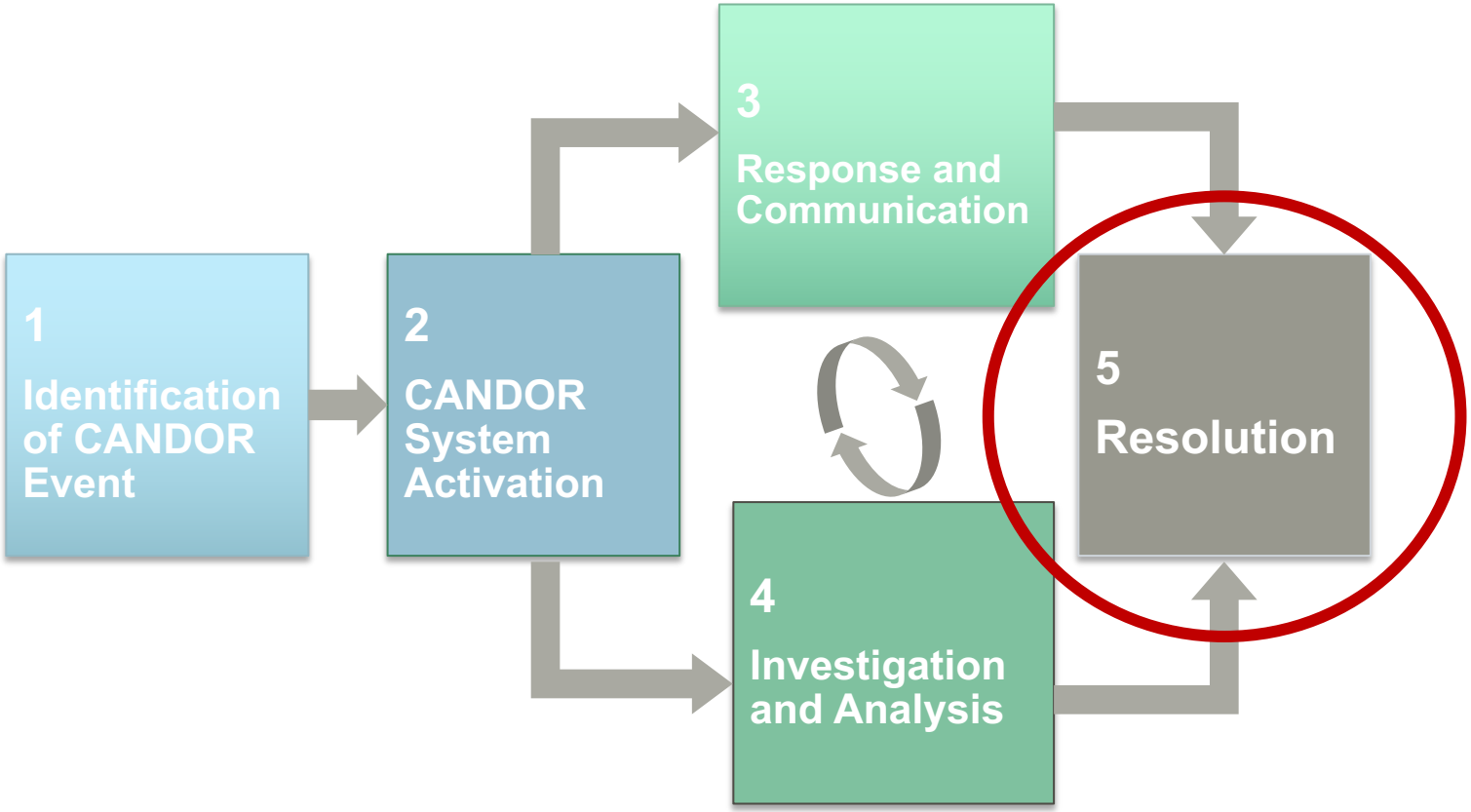
Linda Ubaldi, RN,
CANDOR Training Specialist and Former Quality and Patient Safety Officer, CommonSpirit Health

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

Disclosures

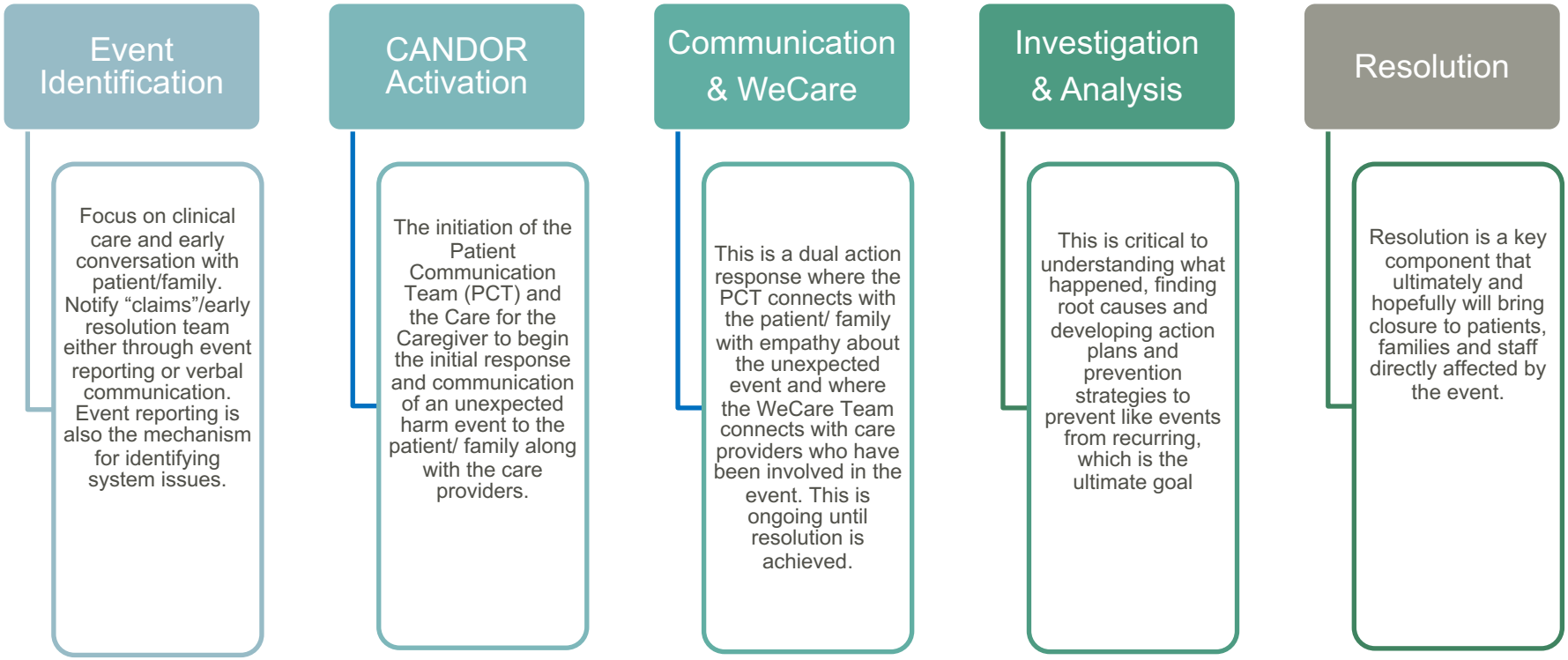
- Today's speakers have no conflicts of interest to disclose

The CRP/CANDOR Process



Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

CRP/CANDOR Components



Terminology

- Claims Professionals
- Claims Manager/Consultants
- CANDOR/CRP Specialists
- Early Resolution Teams
- Patient Safety Officer/Risk Manager

. . . Titles are evolving to capture the essences and intentions.

State Legislation

- Four states with legislation and specific definitions of CRP/CANDOR
  - Colorado
  - Iowa
  - Massachusetts
  - Oregon

Upcoming CAI Webinars

- June 17: Lessons Learned from CRP Cases Gone Wrong
- June 24: CRP 101
- July 15: The Importance of Psychological Safety
- August 19: What helps Physicians after Unplanned Harm
- September 23: How to Engage Physicians in the CRP Process
- October 21: How to Educate Patients and Families about CRPs
- November 18: Ongoing Communication with Patients and Families
- December 16: Intergenerational Harm and CRP

Register Today at https://CRPwebinars.eventbrite.com

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

Today's Approach

- Welcome and Overview
- Critical aspects of strong partnerships for early resolution
- Case 1
  - Case presentation
  - Speaker panel discussion
  - Case resolution
- Case 2
  - Case presentation
  - Speaker panel discussion
  - Case Resolution
- Case 3
  - Case presentation
  - Speaker panel discussion
  - Case Resolution
- Key takeaways and audience Q&A

What must be in place to have a strong, successful partnership with "Claims" for CRP events?

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

Key components for all CRP cases

- Communication must be honest, open, consistent, and empathetic
- Assigned contact person
- Listen to patients and families
- Be transparent with the information
- Ensure early communication and intervention

It's about the patient and the family, not the organization

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

Involve the Team – Early and Often

- Not all claims personnel are able to effectively communicate empathically with patients. Recommend the identification of a core "CRP/CANDOR" resolution team to manage these interactions.
- Claims personnel should complete extensive CRP/CANDOR training and work in collaboration with the PSO/RM.
- The PSO/RM and claims lead should meet prior to their meeting with the patient/family to prepare and practice what will be said identify potential questions and concerns.
- The PSO/RM is typically the patient/family liaison throughout the CRP/CANDOR process.

Prompt and Regular Contact

- Promptly notify Claims (& 3rd parties, if any) of a new CRP to:
  - Facilitate prompt acquisition of records, x-rays, pathology, etc.
  - Facilitate prompt retention of standard of care & causation expert reviews
  - Allow for prompt notice to excess carriers, when applicable
  - Some Claims programs have Litigation/Claims Wellness Support for caregivers that can also be arranged.
- Promptly speak with Claims to share the story and facts surrounding the care, strengthen your partnership and their understanding of the internal processes underway and projected timelines.
- Stay in regular contact with Claims (who can contact 3rd parties' carrier, if any) to coordinate your respective investigations, advise of ongoing communications with Patient/Family and collaboratively set a tentative date for the final Patient/Family meeting
- If the final analysis collectively reached is that the care was appropriate, the Claims representative would not attend the final Patient/Family meeting. Claims should be briefed following the Patient/Family meeting in the event the Patient/Family did not agree and may be seek counsel and assert a claim.

Early Involvement in Patient/Family Meetings

- When internal and external investigations are complete and agreement is reached that the organization is responsible for the outcome, consider extending an invitation to the Claims representative to attend the planning session for the “final” Patient/Family meeting.
- Given the Claim representative’s knowledge of the case they may have good insights into issues that may be raised or should be considered.
- By including the Claim representative as mostly an observer at the final meeting, the Claim representative will have a better first-hand appreciation of the overall picture of how the Patient/Family perceived their care experience in general and as it relates to the medical error, which would be helpful in future contacts with the Patient/Family.
- By including Claims in the final meeting, it also provides a smooth transition and continuity towards the end of meeting to explain that the Claims representative will be following up with them towards reaching a final resolution.
- No settlement discussions should be included in the final Patient/Family meeting.

Resolution Comes in Different Forms

- Resolution is specific to each incident.
- Resolution is being heard, seeking understanding, educating, apologizing, and identifying any needs for change.
- Resolution is healing for the patient/family and providers.
- Resolution is successful when it happens on a timeline that is respectful for the patient/family and providers.
- Resolution can include monetary compensation.

Case Presentations

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

Case 1: Process & Partnership

- Ms. A, a self-employed professional is admitted for elective spleen removal. Surgery was difficult due to her large body mass. Sponge count at beginning and end documented as correct.
- Ms. A. was discharged from hospital day 2 post-op but continued to have post-surgical pain that did not subside with analgesics. Post-op day 11 she spiked a fever with pain persisting. An x-ray revealed a retained sponge.
- The PSO/RM was notified, and the patient underwent a second surgery. The PSO/RM also contacted the patient and family at the time of re-admission, but not the claims manager.
- Ms. A. remained in the hospital due to an intra-abdominal infection before being sent home with a PIC line and antibiotics. The PSO/RM continued to touch base with the family, but the claims manager was not notified.
- After the event investigation, the hospital apologized to Ms. A., but stated no plausible reason for the retained sponge. This angered the patient who wanted to know the names of the staff involved and expected compensation.
- PSO/RM referred Ms. A to the claims management department and was no longer involved. The resolution process was not initiated prior to the patient leaving the hospital.

Case 1 Discussion Questions

- What are the issues at play?
- Who should be involved?
- How do you determine the appropriate resolution? Financial? Other?
- What is needed to resolve this for patients and families in this situation?

- Ms. A, is admitted for elective spleen removal. Sponge count at beginning and end documented as correct.
- Discharged from hospital day 2 post-op but continued to have post-surgical pain. Post-op day 11 she spiked a fever with pain persisting. An x-ray revealed a retained surgical item (sponge).
- The PSO/RM was notified, and the patient underwent a second surgery. The PSO did not contact a claims manager.
- Ms. A. remained in the hospital before being sent home with a PIC line and 14 days of antibiotics. The PSO/RM continued to touch base with the family, but the claims manager was not notified.
- After the event investigation, the hospital apologized to Ms. A., but stated no plausible reason for the retained sponge. This angered the patient who wanted to know the names of the staff involved and expected compensation.
- PSO/RM referred Ms. A to the claims management department. The resolution process was not initiated prior to the patient leaving the hospital.

Case 1 Resolution

- The Patient Safety Officer/Risk Manager should have remained the point of contact for the patient, even when the claims manager was introduced. The PSO/RM had the relationship with the patient.
- The PSO/RM should have partnered with the surgeon to apologize to the patient for their failed processes and share what has been done to make sure it doesn't happen to another patient.
- The patient should not receive any bills for the care related to the retained sponge and a reasonable financial offer should have been planned for and made much earlier in the process.

Case 2: Listening to Patients

- Mr. Z, a 50+ professionally established, healthy male, with a history of aortic valve disease being followed by serial Echo's. Mr. Z presented to the ED after a 10-mile run earlier in the day with shortness of breath. Chest xray was obtained and read as having pneumonia. He was started on antibiotics and sent to the med-surg floor.
- The patient and the family expressed concerns that this could be related to aortic valve disease. While the hospitalist did not think so, she went ahead and ordered an Echo. Mr. Z experienced deteriorating breathing and was transferred to ICU and intubated.
- The Intensivist admitted and treated him for pneumonia, unaware the Echo had been ordered. After 5 days of antibiotics and no improvement, a new intensivist dug deep into the record and found the Echo results confirming severe aortic valve disease requiring immediate open heart surgery.
- The patient would like to talk with a hospital representative about what happened. He felt both he and his family were not listened to. He is experiencing post traumatic stress disorder from his time awake in ICU on a ventilator.

Case 2 Discussion Questions

- What are the issues at play?
- Who should be involved?
- How do you determine the appropriate resolution? Financial? Other?
- What is needed to resolve this for patients and families in this situation?

- A 50+ healthy male, with a history of aortic valve (AV) disease presented to the ED after a 10-mile run earlier in the day with c/o SOB.
- Chest xray read as pneumonia; started on antibiotics and sent to the floor.
- The patient and the family expressed concerns that this could be related to AV disease.
- Hospitalist did not think so but ordered an Echo.
- Patient experienced deteriorating breathing and was transferred to ICU and intubated.
- The Intensivist admitted and treated him for pneumonia, unaware of the Echo.
- After 5 days of antibiotics and no improvement, a new intensivist found the Echo results confirming severe AV disease requiring immediate open heart surgery.
- The patient would like to talk with a hospital representative about what happened. He felt both he and his family were not listened to. He is experiencing PTSD from his time awake in ICU on ventilator.

Case 2 Resolution

- Communications between care givers is a minimal expectation.
- The PSO/RM and claims professional agreed that this was not the proper care.
- They agreed to provide a payment to the patient.

Case 3 Early & Ongoing Collaboration

- Mr. T, a 60+ male, was experiencing worsening neck pain that progressed into numbness in his hands and arms. When an x-ray failed to show abnormalities, he was transferred to a new healthcare facility for an emergent MRI where the physician suspected spinal cord compression that would require surgery.
- Due to pain and claustrophobia, they were unable to complete the MRI. The patient was transferred to the ICU to be evaluated by a spinal surgeon.
- The patient was narcotized, intubated and monitored in the ICU. Due to persistent delays, the MRI was not available until 10 PM.
- The respiratory therapist who accompanied the patient had never transported a patient to the MRI suite and the MRI special procedures technician had worked 14 hours. The critical care nurse left to check on the unit, returning to find the patient had experienced cardiac arrest in the MRI.
- The patient had become disconnected from the ventilator, causing cardiac arrest and subsequent anoxic brain injury. Four days later Mr. T was brain dead.
- The PSO/RM immediately notified the claims manager.

Case 3 Discussion Questions

- What are the issues at play?
- Who should be involved?
- How do you determine the appropriate resolution? Financial? Other?
- What is needed to resolve this for patients and families in this situation?

- 60+ male with neck pain that progressed into numbness was transferred to a new healthcare facility for an MRI when an x-ray failed to show abnormalities. Physician suspected spinal cord compression.
- Unable to complete the MRI due to claustrophobia; patient transferred to the ICU where he was narcotized, intubated, and monitored. The MRI did not become available until later that evening.
- Respiratory therapist who accompanied the patient had never transported a patient to the MRI suite and the MRI technician had worked 16 hours. Critical care nurse returned to find the patient had experience cardiac arrest in the MRI.
- The patient had become disconnected from the ventilator causing cardiac arrest and anoxic brain injury.
- The patient was brain dead four days later.
- The PSO/RM immediately notified the claims manager.

Case 3 Resolution

- The claims manager was a part of the RCA and sat in on the meetings with the family, physician and patient safety officer.
- The family was encouraged to contact an attorney for help in crafting their demands.
- The claims manager committed to working with the attorney toward swift and just resolution.
- No lawsuit was ever filed, and the case was settled within a reasonable timeframe for all parties.

Guiding Principles for a Strong Partnership with “Resolution” Team

1. Resolution is a team sport - the claims professional/early resolution team is a key part of the team from the beginning although they may not actually “meet” the family until later in the CRP process. Claims professionals should completed extensive training on CRP/CANDOR along with other leaders in the organization.

2. Claims professional/early resolution team is a patient safety resource...tap into that resource immediately and often. Notify the claims manager/early resolution team immediately. They are also a key stakeholder in the resolution process.

3. Resolution comes in many forms, not solely financial.

Key components for all CRP/CANDOR cases

- Communication must be honest, open, consistent, and empathetic.
- Assign contact person.
- Listen to patients and families.
- Be transparent with the information.
- Ensure early communication and intervention.

It's about the patient and the family, not the organization.

Thank you

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT