The Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) is a healthcare alliance formed in 2012 and comprising some of the most notable health and medical groups in the Commonwealth of Massachusetts. These include major teaching hospitals and their insurers, statewide provider organizations, and patient advocacy groups. Ten healthcare facilities/groups have implemented the Communication, Apology, and Resolution (CARe) model and share their experiences and lessons learned to aid in the dissemination of CARe throughout Massachusetts, and eventually other states.

MACRMI is committed to the implementation of Communication, Apology, and Resolution (CARe) following medical injury. Prompt recognition of, and response to, medical injury, along with appropriate compensation to the patient or family, has demonstrated potential to improve patient safety, reduce medical costs, and enhance fairness and transparency in health care. It is, simply, the right thing to do.

There are many free resources available for healthcare institutions, patients, and attorneys at our website: [www.macrmi.info](http://www.macrmi.info). Below is a list of our most requested resources:

<table>
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<th>Resource Title</th>
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<td>A Roadmap for Transforming Medical Liability and Improving Patient Safety in Massachusetts (Executive Summary)</td>
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<tr>
<td>Best Practices for CARe Institutions</td>
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<td>Best Practices for Interfacing with Patients</td>
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<td>Best Practices for Patient Representation</td>
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<td>CARe Readiness Checklist</td>
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<td>CARe Timeline (see reverse of this handout)</td>
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<td>How to Implement a CARe Program: An Implementation Guide</td>
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<td>Informational Patient Brochure</td>
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<td>Health Affairs articles with Pilot Data</td>
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<td>Patients’ and Physicians’ Attitudes Regarding the Disclosure of Medical Errors</td>
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<td>The Disclosure and Offer Model: Understanding the Basics</td>
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<td>Unexpected Medical Outcome: Patient Info Sheet</td>
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CARe Timeline

24-48 hours after event
(algorithm steps 1, 2)

1. Patient Safety Alerted
   Support services for providers and patients launched
   Discussion with patient regarding error and known facts

2. Internal investigation takes place
   Patient Safety and Patient Relations maintain contact with providers and patients respectively

3. Determination of CARe criteria fit
   Providers, Chiefs, and Directors consulted
   Team huddle; designee conducts Initial CARe Communication with the patient; connects them to Insurer for record release

4. Insurer reviews case and develops offer parameters
   Provider/System Allocation by insurer
   Insurer invites patient to CARe Initial Meeting; recommends that counsel also attend
   Corrective actions implemented at site

5. Initial meeting with insurers, providers, patient safety staff, patient, counsel, and other parties
   Additional resolution meetings occur as necessary
   Financial offer to patient made and accepted or rejected (settlement may be negotiated)

6-5 months after event
(algorithm steps 6, 7, 8, 9)

1. DPH SRE Letter Templates
   Risk Managers

2. Sample Communication Policy
   Risk Managers

3. Risk Managers/All Staff
   Best Practices for Interfacing with Patients
   Patient Relations
   Unexpected Outcome Sheet
   Patients

4. CARe Algorithms
   Risk Managers

5. Insurer Referral Document (to be finished)
   Patient Relations/Risk Managers

6. Best Practices for Patient Representation
   Risk Managers/Insurers

7. Suggested Insurer Contact Timeline
   Insurers

8. Guidelines for Initial CARe meeting
   Risk Managers/Insurers

9. Best Practices for Attorneys Representing Patients
   Attorneys

10. Best Practices for Attorneys Representing Providers
    Attorneys

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