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DOI: 10.1377/hlthaff.2018.0727
HEALTH AFFAIRS 37,
NO. 11 (2018): 1845–1852

Can Communication-And-Resolution Programs Achieve Their Potential? Five Key Questions

ABSTRACT Communication-and-resolution programs (CRPs) are intended to promote accountability, transparency, and learning after adverse events. In this article we address five key challenges to the programs' future success: implementation fidelity, the evidence base for CRPs and their link to patient safety, fair compensation of harmed patients, alignment of CRP design with participants' needs, and public policy on CRPs. While the field has arrived at an understanding of the core communication-and-resolution practices, limited adherence fuels skepticism that programs are meeting the needs of patients and families who have been injured by care or improving patient safety. Adherence to communication-and-resolution practices could be enhanced by adopting measures of CRP quality and implementing programs in a comprehensive, principled, and systematic manner. Of particular importance is offering fair compensation to patients in CRPs and supporting their right to attorney representation. There is evidence that the use of CRPs reduces liability costs, but research on other outcomes is limited. Additional research is especially needed on the links between CRPs and quality and on the programs' alignment with patients' and families' needs. By honoring principles of transparency, quality improvement, and patient and family empowerment, organizations can use their CRPs to help revitalize the medical profession.

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This is an exciting time for communication-and-resolution programs (CRPs)—innovative programs that enable health professionals, health care facilities, and liability insurers to communicate openly with patients and families about adverse events, investigate their causes, explain what happened, apologize, and offer compensation if substandard care caused patient harm.[1] CRPs were first used in the Department of Veterans Affairs Health System and academic medical centers, but they have spread to approximately two hundred diverse US organizations.[2] Moreover, these programs are increasingly integral to patient safety systems, furthering the clinical missions of health care organizations.[3,4]

Efforts to improve the way health care providers respond to medical errors began in the 1980s and stressed that disclosing adverse events to patients was a moral and professional responsibility.[5] Over the next decade a few health systems created programs to support clinicians in conducting disclosure conversations. In the late 1990s several organizations developed approaches that coupled disclosure with proactive compensation in cases of substandard care.[6,7] The Joint Commission's 2001 accreditation standard requiring that unanticipated outcomes be disclosed to patients created further momen-

tum.[8] Since that time, there has been additional development of the notion that disclosure should be part of a systematic institutional response to injury that includes reconciliation with the patient and support for involved caregivers. Contemporary thinking about the essential features of a CRP is represented by the Agency for Healthcare Research and Quality's Communication and Optimal Resolution (CANDOR) Toolkit, a synthesis of best practices.[9]

In this article we discuss five critical questions, the answers to which will shape the future of CRPs.

Question 1: How Can Greater Adherence To Core Communication-And-Resolution Practices Be Encouraged?

Until recently, the key components of communication-and-resolution practices were still evolving. Early work recognized two CRP models: the "early settlement" model, typified by the University of Michigan, and the "limited reimbursement" approach popularized by COPIC, a Colorado liability insurer.[10] Over time, the CRP field converged around a single set of practices: transparency (early reporting of adverse events and open communication with patients and families); quality improvement; emotional support for patients, families, and clinicians; and proactive offers of financial compensation when the harm was caused by unreasonable care.[9,11–13]

Today, there is concern about whether organizations consistently adhere to these practices. Some demonstration projects have identified substantial gaps in implementation fidelity.[14,15] Selective use of CRPs takes two forms. First, organizations may avoid using their CRP in cases where patients seem unlikely to assert a malpractice claim.[14,15] Second, organizations may apply some but not all CRP practices to a given case. For instance, an organization may emphasize transparent communication about the event but not offer compensation proactively.[14,16] Critics have questioned whether institutions are faithfully offering compensation, noting that increasing the number of compensation offers may be contrary to institutional financial interests.[17]

Lack of CRP implementation fidelity is problematic because some patients are not benefiting from the approach. Inconsistent implementation also undermines the desirable cultural transformation toward universal transparency that confers new opportunities to improve safety. In addition, inconsistency can confound evaluation of the CRP model: If CRPs fail to reduce costs or yield safety improvements, it is difficult to know whether the fault lies in conceptual shortcomings or incomplete implementation.

Rigorous metrics for assessing CRP structure, process, and outcomes would help institutions increase their fidelity to communication-and-resolution practices. A project is under way to develop metrics assessing each CRP component, sponsored by donations from two families whose loved ones died from medical errors. Teams at the University of Washington and Ariadne Labs are leading a project using national experts to create the metrics, which will be tested in two health systems, finalized, and then disseminated in late 2019.[12] Initially, the metrics could be used internally by institutions to improve their CRPs. Over time, the metrics could also be used externally to benchmark CRPs and recognize organizations with high-functioning CRPs through accreditation or pay-for-performance programs.

Organizations such the national Collaborative for Accountability and Improvement and the Massachusetts Alliance for Communication and Resolution after Medical Injury (MACRMI) seek to advance CRPs by publicizing best practices based on lessons learned from CRP pioneers.[10] For example, robust training can increase the likelihood that health care professionals will participate effectively in CRPs.[18] In addition, conducting gap analyses can help institutions assess how their CRP is functioning and understand what changes are needed.[9]

Ultimately, greater adherence to core communication-and-resolution practices will happen only when organizations embrace the philosophical commitments underlying CRPs. Organizations adopting CRPs must regard them as comprehensive, principled, and systematic. *Comprehensive* means implementing all CRP components as a package; *principled* means using CRPs for every eligible event; and *systematic* means hardwiring the CRP components to work together and connecting the CRP to other institutional management systems such as quality, safety, and risk-management programs that detect and respond to adverse events. Research on the implementation of specific CRP components could identify organizational barriers and facilitators of success, further increasing the chances that organizations with CRPs will consistently "walk the walk."

Question 2: Are Communication-And-Resolution Practices Evidence Based And Linked To Patient Safety?

The CRP concept had its origins in research documenting patients' beliefs that the response to medical injury should include openness, accountability, and learning.[19] However, the main emphasis in evaluations of CRPs has been on

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liability outcomes, reflecting stakeholders' concerns that the approach would substantially increase medicolegal costs.[20] Even in this domain, it was unknown what effects CRPs were having until 1999, when research on pioneering CRPs documented reductions in the volume and costs of malpractice claims.[6,21] Positive results were later reported at two different organizations,[22,23] though two others have reported more modest effects.[14,24]

In theory, CRPs could have benefits beyond liability outcomes, especially for patient safety. Safety culture should improve as the programs encourage internal reporting of harmful events and help organizations learn from them. Comprehensive systems for measuring patient safety are also critical for improving safety[25] and should be reinforced by CRPs' focus on tracking improvements. Finally, enhanced measurement systems, culture, and transparency make adverse events more visible, bolstering the motivation to reduce them.

Pinpointing the impact of CRPs on patient safety is difficult, however. Organizations that adopt CRPs are simultaneously pursuing other patient safety initiatives, which makes it challenging to isolate the CRPs' unique contributions. Nonetheless, evidence suggests that CRP implementation is correlated with improvement in at least one safety-measurement system: incident reporting. One study reported significant increases in event reports and analyses from use of a CRP. This study also found greater use of experts to help front-line clinicians communicate with patients and families about adverse events.[22] Theoretically, CRPs should also encourage more open discussion about the causes of adverse events as clinicians become less fearful of lawsuits and overall safety culture improves. However, this remains to be proven.

If the evidence of CRPs' benefits beyond liability outcomes is weak, what is driving the programs' adoption? Studies suggest that early CRP adopters were driven by ethical motivations—the belief that CRPs were "the right thing to do"—coupled with optimism that they could have a positive (or at least neutral) effect on liability costs.[10] Some early adopters also found that CRPs complemented efforts to bring joy and meaning to the workplace, especially for physicians,[26] which could improve staff engagement and reduce burnout.

Maximizing CRPs' impact on patient safety will require developing the evidence base regarding how to integrate them into highly reliable, learning health care organizations. One critical empirical question is how to maintain leadership commitment to integrating communication-and-resolution principles and practices into an organization's quality, patient safety, risk and claims management, and patient relations functions. Research is also needed to examine how organizations can improve internal adverse event reporting, develop a nonpunitive safety culture that encourages such reporting, implement human-factors-based approaches for adverse event investigation and analysis, generate system-based solutions for adverse events, and improve peer review.

In summary, the evidence base for CRPs is limited except in the domain of liability outcomes, and the link between the programs and patient safety is largely theoretical. To some extent, it is encouraging that organizations find the case for CRPs compelling enough to move forward, absent definitive data supporting the entire model. In the short run, recognizing CRPs as a patient safety innovation should spur organizations to apply the process improvement lens to their programs, monitoring performance metrics and using the data for rapid-cycle tests of change. In the long run, a stronger research base is needed to demonstrate that CRPs improve patient safety, measure the benefits (or lack thereof) to all stakeholders, and determine the best way to design specific components of CRPs.

Question 3: Are Offers Of Compensation Made In Communication-And-Resolution Programs Fair To Patients?

Addressing skeptics' concerns about the fairness of compensation offers will be important to CRPs' long-term success. The most biting critique of the programs is that they could take financial advantage of patients, reinforcing concerns that they are just a new way to settle claims cheaply. Skeptics worry that without plaintiff attorneys and judges involved, CRPs resemble

the fox guarding the henhouse.[27]

The fairness of CRPs has not been adequately evaluated. One possible reason is the complexity of the concept. What constitutes a fair compensation offer? One dimension is horizontal equity—the idea that patients with injuries of similar severity should receive comparable compensation. A second dimension is vertical equity, which implies that compensation should increase with injury severity. A third is that CRP offers should mirror the value of the injury in litigation. This third view poses three challenges. First, how should compensation be adjusted for the fact that early offers mean legal expenses for the patient's attorney will be lower, and the attorney thus should receive less than the one-third of the settlement she would ordinarily take? Second, given the known problems with vertical and horizontal equity in malpractice awards,[28] prior awards have limited utility as a benchmark of fairness. Third, as more institutions shift to CRPs, the cases remaining in litigation will constitute a nonrepresentative sample and a weaker signal of what patients with similar injuries are receiving.

We suggest two principles for moving forward. First, fair CRP compensation is most likely to occur when certain processes are followed. Patients should be represented by an attorney when it becomes evident that compensation will be offered. To connect patients with qualified attorneys, CRPs should ask local bar associations to develop a referral list of experienced attorneys who understand the CRP model and will consider alternatives to the standard contingency fee of one-third of the settlement amount.[29] Organizations should be transparent with the patient and attorney about how they arrived at the offer amount. Ideally, they would share information about other recent settlements for injuries of comparable severity. Organizations should not lower the offer because of intangible factors regarding the defensibility of the case—for example, how sympathetic the patient would appear to a jury, or whether the case could be defended on a technicality. Finally, CRPs should track metrics showing how closely they adhere to these criteria for deeming an event compensable.

Second, to test our suggestion to focus on procedural fairness, more work should be done to understand how patients and family members in communication-and-resolution processes think about fair compensation. We are aware of only one study in this area,[30] which found that eleven of twenty-seven patients were dissatisfied with the compensation they received. Further research should examine whether patients' perceptions of procedural fairness influence the perceived fairness of the outcome.

Early attempts to design policy supports for CRPs faced skepticism on both sides of the tort reform divide.

Question 4: How Can Communication-And-Resolution Programs Ensure Their Alignment With Participants' Needs?

Few studies have assessed patients' and families' experiences in CRPs. Multiple barriers have inhibited such research, such as concerns about further traumatizing harmed patients and institutions' fear of angering patients who could still sue.[16]

One study demonstrated that such hurdles can be overcome. In interviews with thirty patients and family members who participated in CRPs at three hospitals—albeit only people who had settlement agreements or whose time for bringing a lawsuit had expired—the researchers found that 60 percent reported the overall experience as positive, and the same proportion continued care at the same hospital.[16] This study and others highlight several key issues that require further research.[31,32]

First, the experience of adverse events can have large and prolonged emotional, psychosocial, and financial impacts on patients and families.[31] Second, patients and families do not always perceive communications after harmful events to be authentic and transparent, which compounds their injury.[16,30,31] Third, widely used CRP terms are not patient centered. For example, *disclosure* implies something hidden, and *resolution* might not reflect participants' experiences of "unresolvable" loss.[32] Fourth, studies assessing the quality of disclosure conversations are extremely limited.

A growing body of evidence highlights a role for patients in postevent learning.[33] Guidelines such as the National Patient Safety Foundation's Improving Root Cause Analyses and Actions (RCA^2) advocate engaging patients in event investigations.[34] Emerging tools to interview patients and families can help guide organizations

but need further testing.[35]

While acknowledging that a CRP's top priority is meeting patient and family needs, the programs should also routinely support all care team members involved in adverse events.[36,37] Early CRP research highlighted the emotional distress that clinicians experience after medical errors, the limited support available for affected clinicians, and the link between inadequate support and an increased likelihood of future errors.[38–40]

Tools to support clinicians after adverse events are robust and expanding quickly.[41] Physicians also report that transparency with patients after an event helps them move through adversity more positively.[42] Peer-support programs can enhance providers' wellness and resilience and can augment efforts to prevent burnout and suicide.[26]

In summary, CRPs could improve their alignment with participants' needs by enhancing communication with patients and families in the immediate aftermath of adverse events; engaging them in postevent learning; and addressing the long-term social, emotional, and financial consequences of harmful errors. Similarly, CRPs should provide additional emotional support for and engagement with clinicians.

Question 5: How Can State And Federal Policy Makers Best Support Communication-And-Resolution Programs Going Forward?

The legal context for CRPs continues to evolve (exhibit 1), not only in its substantive provisions but also in what CRP law signals about lawmakers' assumptions and priorities.[43] The commitments and procedures associated with CRPs initially were viewed by policy makers primarily as modifications to medical malpractice litigation, rather than as a way to advance a broader ethical or quality-oriented agenda. This was not surprising: Medical malpractice policy ("tort reform") has seldom been integrated with other health policy issues. Malpractice policy has unique emotional resonance for the medical profession, its governance is more state than federal and more judicial than legislative or regulatory, and its politics extend beyond health care to the larger civil justice system.[44]

Early attempts to design policy supports for CRPs faced skepticism on both sides of the tort reform divide. Pennsylvania's groundbreaking 2002 law that required hospitals to disclose "serious events" to patients was contained in the "patient safety" section of a larger malpractice reform statute, but it was viewed by provider constituencies as a trial lawyer trick to gin up lawsuits.[44] Physician groups and liability insurers portrayed voluntary CRPs as expensive and risky unless accompanied by caps on damages or other measures to discourage litigation.[20] This prompted a backlash from the trial bar, which also worried about CRPs manipulating patients into settling claims too cheaply. Such attempts to squeeze CRPs into the conventional tort reform debate heightened concern among scholars that the programs would at best mediate between litigation adversaries and might devolve into a façade for partisanship. At the same time, however, early adopters of CRPs succeeded in a vari-

EXHIBIT 1

Key elements of the evolving legal context for communication-and-resolution programs (CRPs)

	CRP chronology		
	Early	**Recent**	**Future**
Essential question	Will transparency decrease or increase liability costs?	Can CRPs be replicated in nonacademic settings and scaled?	Do CRPs improve patient safety and meet patients' expectations?
Goal of laws related to disclosure of adverse events	Allaying physicians' and hospitals' fears of lawsuits and reputational harm	Overcoming real and perceived barriers to resolving claims using CRP-style approaches	Supporting best practices of CRPs
Relationship to malpractice tort reform	Stakeholder-negotiated part of tort reform	Patient safety supplement to tort reform	Quality and accountability tool independent of tort reform
Approach to physicians	Persuasion to consider	Reassurance to participate	Expectation to meet professional duty
Extent of transparency	Single disclosure event following harm	Outreach to patient and family following harm and negotiation of resolution	Institutional process of systematic communication with patients and families that emphasizes mutual respect, learning, and safety improvement

SOURCE Authors' analysis.

ety of state legal environments, some of which were hostile to tort reform. Local trust building rather than legislative action was key to their success.

The policy conversation changed as CRPs gained national attention, which happened in part because a long-ignored report by the Institute of Medicine[45] for the administration of President George W. Bush that endorsed CRP principles was unexpectedly resurrected by the administration of President Barack Obama in the form of demonstration programs funded and administered by the Agency for Healthcare Research and Quality.[46] Although calls for legal support have become less opportunistic—no longer conditioning CRPs on tort reform—most retain their risk-management tone and promote CRP practices by catering to physicians' preconceptions and concerns about malpractice suits. Policy interventions taking this tactical approach include "shield laws" prohibiting apologies from being offered into evidence (adopted in roughly two-thirds of the states, but without evidence of effectiveness), proposals that payments made to patients through CRPs be exempt from otherwise required reporting to the National Practitioner Data Bank (a change thus far rejected by the federal government), and mandatory cooling-off periods before a lawsuit can be filed.[47] Even the three state laws—in Iowa, Massachusetts, and Oregon—that were enacted specifically to facilitate CRPs have stressed reassurance of providers over solidarity with injured patients.[48–50] As was the case with the debate over caps on damages discussed above, successful CRPs (including in those three states) see the goals slightly differently, supporting these measures but also emphasizing improvements that are less intuitive to the average physician, such as securing legal representation for injured patients.[29]

Going forward, there are strong arguments for viewing CRPs as essential components of high-quality, ethical medical care rather than as alternative dispute resolution processes that compete with civil litigation. Accordingly, the policy changes most important to future CRPs will further best practices, address specific impediments, and integrate CRPs with other health regulatory frameworks. For example, since 2002 ten states have enacted requirements to disclose adverse events, typically as political compromises in connection with liability-limiting tort reforms.[44,47] Such requirements support the key element of open communication in CRPs. Now that physicians and provider organizations generally acknowledge transparency as an ethical obligation, having state law require the communication of facts about unexpected harm sends a respectful and caring message to patients, while strengthening incentives for hospitals to develop full-blown CRPs that support those disclosures. Other best practices that states might legislate include clearly specifying the documents and records that should be shared with patients and families and building communication-and-resolution principles into continuing medical education requirements.

Organizations that implement CRPs should strive for fidelity to the model and rigorously evaluate their performance with meaningful metrics.

Measures to address specific impediments to effective CRPs include revising a provision of federal law entitling the government to recapture Medicare payments if another party takes responsibility for the cost of care. When the Medicare program asserts this "subrogation right," the process of figuring out what is owed to Medicare can delay and unsettle compensation to injured Medicare patients through CRPs. In addition, policy makers should work with the National Practitioner Data Bank to include details of CRP processes in mandatory reports of malpractice payments, without which physicians may be unfairly blamed for errors. Similarly, policy makers should engage state licensing boards to ensure that professional disciplinary processes and associated reporting requirements are not at cross-purposes with the open, nonpunitive CRP approach. Policy makers also should prohibit malpractice insurers from placing language in liability insurance policies that inhibits physician disclosure or apology.

Because CRPs reflect professional and institutional priorities beyond resolving malpractice claims, it is particularly important that both private and public payers take account of CRPs in designing new payment systems and accountability metrics. For example, Medicare payment adjustments associated with avoidable harm (not reimbursing for "never events" and assess-

ing readmission penalties) should not be triggered solely because a CRP has assisted an injured patient. Also, patient-oriented quality indicators should be developed that measure how frequently providers adhere to CRP practices in responding to harm events.

Conclusion

The communication-and-resolution program field has considerable promise but faces important challenges. As programs proliferate and mature, achieving their potential will require a sustained, collective effort involving diverse stakeholders. Organizations that implement CRPs should strive for fidelity to the model and rigorously evaluate their performance with meaningful metrics. Closer partnerships and longer follow-up with patients and families who have been served by CRPs will be essential to understanding their experiences. Momentum for CRPs will continue to build without supportive legal reforms, but policy makers should consider how they might accelerate it, perhaps transitioning from voluntary to more prescriptive requirements.

In his essay "Era 3 for Medicine and Health Care," Donald Berwick called for health care to move toward a "moral era," rejecting both the prior mode of professional dominance and the current emphasis on measures, incentives, and market theory.[51] CRPs, with their commitments to transparency, improvement, and empowerment of patients and families, can hasten the arrival of this new era and contribute to a revitalization of the medical profession. ■

This work was supported in part by a grant from the Agency for Healthcare Research and Quality (No. R18HS024504).

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