Challenges of Implementing a Communication-and-Resolution Program Where Multiple Organizations Must Cooperate

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Objective. To implement a communication-and-resolution program (CRP) in a setting in which liability insurers and health care facilities must collaborate to resolve incidents involving a facility and separately insured clinicians.

Study Setting. Six hospitals and clinics and a liability insurer in Washington State.

Study Design. Sites designed and implemented CRPs and contributed information about cases and operational challenges over 20 months. Data were qualitatively analyzed.

Data Collection Methods. Data from interviews with personnel responsible for CRP implementation were triangulated with data on program cases collected by sites and notes recorded during meetings with sites and among project team members.

Principal Findings. Sites experienced small victories in resolving particular cases and streamlining some working relationships, but they were unable to successfully implement a collaborative CRP. Barriers included the insurer's distance from the point of care, passive rather than active support from top leaders, coordinating across departments and organizations, workload, nonparticipation by some physicians, and over-coming distrust.

Conclusions. Operating CRPs where multiple organizations must collaborate can be highly challenging. Success likely requires several preconditions, including preexisting trust among organizations, active leadership engagement, physicians' commitment to participate, mechanisms for quickly transmitting information to insurers, tolerance for missteps, and clear protocols for joint investigations and resolutions.

Key Words. Medical liability, malpractice, patient safety, communication, medical error

Early adopters of communication-and-resolution programs (CRPs), in which health care organizations communicate with patients about adverse events and their causes, use investigation findings to improve patient safety, and they proactively offer compensation where substandard care caused harm, have

reported considerable reductions in malpractice claims costs (Kraman and Hamm 1999; Boothman et al. 2009; Kachalia et al. 2010; Mello and Gallagher 2010; Kachalia and Mello 2011; Mello et al. 2014a; Grenon et al. 2015). Interest in these anecdotal successes has led to substantial investments by the Agency for Healthcare Research and Quality (AHRQ) to further test the approach (Agency for Healthcare Research and Quality 2010) and develop tools to scale it for nationwide implementation (Agency for Healthcare Research and Quality 2016).

Because most early CRP adopters are academic medical centers (AMCs), questions have arisen about the exportability of their experience to “open” settings in which physicians are not employed or insured by the hospital. Several circumstances may make it more difficult to garner physician participation in adverse event reporting, disclosure, and early settlement in open organizations. Employing and insuring physicians may give AMCs more levers to influence physicians’ behavior than other hospitals have (Mello et al. 2014b), and direct employment creates an immersive practice experience for physicians in which institutional culture and priorities are more readily transmitted. Furthermore, early CRP adopters found that the prospect of having a settlement reported in their name to the National Practitioner Data Bank chilled physicians’ willingness to disclose errors and offer compensation, and AMCs could respond in some cases by settling in the name of the hospital (Mello et al. 2014a,b). This practice may be less palatable to hospitals that have an arm’s-length relationship with the involved physicians and is not an option for physician insurers.

Another set of issues pertains to resolution processes. When a physician and hospital are insured by different companies, investigation and resolution of adverse events may be siloed, duplicative, and protracted. The parties have incentives to shift blame for medical errors to one another rather than collaborate on a joint resolution. Staff at different insurance entities may approach claims management differently, with some more inclined toward transparency and early resolution and others toward the traditional, “deny and defend”

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model. Although AMCs encounter such situations in claims involving care by outside providers, the typical case for them lies within the institution's walls. Virtually every aspect of CRPs would appear to be more complex to execute in an open setting. These challenges affect the ability both to successfully resolve incidents with patients and to identify and implement patient safety improvements based on lessons learned.

Yet many organizations in such settings are committed to the principles of CRPs and interested in trying the approach. With funding from AHRQ, a group of hospitals and multispecialty physician clinics and a large physician insurer in Washington State collaborated with academic researchers in a 4-year demonstration project to test whether they could effectively collaborate to apply the CRP approach. There was particular interest in using the CRP to resolve cases that involved both a facility and a separately insured physician—for example, a hospital and an obstetrician covered by the physician insurer. Here, we report the organizations' experiences implementing the program.

SETTING

Project sites included a large mutual medical-professional liability insurer (hereinafter "Insurer") and six health care facilities in Washington State. Insurer insured physicians practicing at all but one of the facilities. The proportion of physicians it insured varied across the five facilities, from a minority to all physicians. The facilities were three hospitals that were members of the same nonprofit hospital system and three multispecialty physician clinics (see Figure 1 and Table 1 for details and identifiers used hereinafter). The insurers exercised substantial control over how malpractice claims were resolved at their insured facilities.

Project planning began with academic researchers developing a relationship with Insurer. Insurer then invited health care institutions and physician groups with which it had relationships to consider participating in the project. The project was presented as an intervention to improve patient safety and medical liability outcomes. In addition to the CRP, its components included team communication training aimed at reducing adverse events (Team-STEPPS) and disclosure training for strengthening communication with patients after harm occurs.

When organizations expressed interest, the academic researchers reached out to provide additional information and finalize commitments. The final project sites were selected to provide diversity in institutional size,

Figure 1: Relationships among Participating Health Care Facilities and Insurers

geographic location within Washington, and care delivery models. It was agreed at the outset that Insurer and the facilities would contribute to the design of the CRP; that the project team supporting implementation and evaluation of the CRP would include both academic researchers and Insurer representatives; and that evaluation data would be collected and seen by the academic researchers only.

The project included a yearlong CRP design phase followed by 20 months of CRP implementation and evaluation. During the design phase, sites collaborated with project team members and one another to agree on a set of Key Elements and Guiding Principles for the CRP and on event eligibility criteria (see Box 1). This design process involved several in-person, large group meetings that included the sites and other key stakeholders (such as defense attorneys and patient advocates) and extensive email review and refinement. The kick-off design meeting included a presentation by the architect and director of the University of Michigan CRP.

The CRP design shared several core features with the University of Michigan model (Boothman et al. 2009), and it also included procedures for organizations to communicate, make joint decisions, and resolve disputes. Like the Michigan model, the Key Elements emphasized the centrality of

Table 1: Characteristics of Participating Health Care Facilities and Insurers

<i>Identifier</i>	<i>Description</i>	<i>Number of Individuals Interviewed</i>	
		<i>Baseline</i>	<i>End of Project</i>
Insurer	A mutual medical-professional liability insurer based in Washington State	7	8
System A	A not-for-profit, regional health care system. Although risk management functions are carried out at the hospital level, the System's central administration plays a major role in managing malpractice claims. The system self-insures for the professional liability acts of employees. Most physicians with clinical privileges at system hospitals, however, are not employed and carry their own professional liability insurance	2*	2*
Facility A1	A medium-sized (250–500 bed), acute-care general hospital in an urban area. Owned and operated by System A	2	2
Facility A2	A large (>500 bed), acute-care general hospital in an urban area. Owned and operated by System A	2	2
Facility A3	A small (<250 bed), acute-care general hospital in a rural area. Owned and operated by System A	2	2
Facility B	A multispecialty, physician-owned clinic providing outpatient care and surgery in an urban area. The clinic's professional liability insurance carrier is Insurer	2	2
Facility C	A multispecialty, physician-owned clinic providing outpatient care and surgery in an urban area. The clinic's professional liability insurance carrier is Insurer	3	3
Facility D	A multispecialty, physician-owned clinic providing outpatient care and surgery in an urban area. The clinic self-insures for professional liability through a risk retention group	3	2

*Respondents were affiliated with System A's central administration.

patient safety improvement throughout the CRP process. For example, they specified that when partners collaborated to resolve events, they must seek to “identify possible systems improvements to prevent recurrence and a strategy to ensure implementation.”

Preceding implementation, each site was given a 50-page workbook to assist in aligning its policies and procedures with the CRP Key Elements, and project team members conducted interviews and reviewed existing policies to identify areas where changes were needed. With a signature from the chief medical officer or other senior administrative leader, all sites, including Insurer, committed themselves to the CRP Key

Box 1: Communication-and-Resolution Program Key Elements*

1. Patients will be informed of all important facts regarding their health care, including unanticipated outcomes.
2. Partners commit to implement a Just Culture within their organizations.
3. Partners commit to supporting and training their staff to appreciate the impact of an unanticipated outcome of care on the health care team and to communicate effectively with patients after an unanticipated outcome.
4. Partners agree to voluntarily collaborate in good faith after the occurrence of an unanticipated outcome that qualifies as a “study event” (SE) to ensure a prompt investigation and to craft and negotiate a proposed resolution. An SE is defined as an unanticipated outcome of care that involves or may involve harm to the patient.
5. When an SE occurs, the care team ascertains and responds to the patient’s immediate health needs; and involved Partner staff or providers report the SE to the designated risk manager or staff within 12 hours to:
 - trigger investigation using a Just Culture approach;
 - initiate support services to the family and care team;
 - obtain coaching regarding the initial disclosure to the patient/family;
 - identify a case manager to evaluate the patient’s short- and long-term needs; and
 - hold patient billing pending further evaluation.
6. As soon as is feasible after an SE, and ordinarily within 24 hours, the designated risk manager contacts other involved Partners to explain the occurrence and steps taken in response and initiate a voluntary collaborative response to the SE.
7. As soon as is feasible after an SE, and ordinarily within 24 hours, the care team provides the following information, as appropriate, to the patient/family:
 - the fact that an unexpected care outcome occurred;
 - the clinical circumstances surrounding the SE, including any information known with a high degree of certainty about why it happened;
 - the impact of the SE on the patient’s health, treatment, and follow-up;
 - an appropriate apology; and
 - an assurance that additional information about what happened and what steps, if any, will be taken to prevent a recurrence will be forthcoming as soon as it can be ascertained and when applicable.
8. Partners and involved providers collaboratively decide on an approach to an expedited Care Assessment and Review of Event (CARE), in order to determine whether (1) the health care provided was reasonable under the circumstances, (2) immediate system improvements are necessary to avoid recurrence, and (3) other actions are warranted.
9. After completion of CARE, Partners and involved providers meet to review findings; evaluate the patient’s short- and long-term needs; determine a joint approach to resolution, including a decision about compensation and an approach to negotiation and to subsequent disclosures to the patient/family; and identify possible systems improvements to prevent recurrence and a strategy to ensure implementation.
10. After a joint approach to resolution is determined, the patient/family is notified of the findings and the Partners’ intention. Resolution consists of an explanation of findings and either an offer of compensation or an explanation of why no compensation will be offered; as well as an explanation of what actions, if any, will be taken to prevent recurrence of the SE.

Continued

Box 1. *Continued*

11. At any time, the patient or the involved providers may seek legal representation. The patient or his/her representative will be encouraged to seek legal representation in any situation where it will benefit the process.
12. Partners, involved providers, or patients may opt out of the CRP process at any time.
13. Partners agree to comply with all state and federal mandatory reporting requirements relating to the provision of health care and resolution of SEs.

*Adapted from program implementation workbook, available from the senior author upon request.

Elements and Guiding Principles, which prominently featured commitments to improving patient safety. They were asked to itemize specific steps they planned to take to ensure that each CRP Key Element was implemented, along with who was responsible. Furthermore, they were also asked to “identify and energize clinical ‘champions’” within the institution to spearhead CRP implementation. These champions were meant to be clinical peers with a track record of leading institutional initiatives in the quality/safety domain. Beyond completion of the workbook, specific implementation plans were left up to the sites.

Project leaders provided training sessions on team communication, disclosure skills, and program evaluation methods. The project did not provide financial support to participating facilities, but it did provide a modest annual allocation to Insurer, whose staff provided some of the training and support to the facilities.

EVALUATION DATA AND METHODS

The methodology for assessing implementation experiences was similar to that of another demonstration project in New York (Mello et al. 2014b), and it involved triangulating information from three sources. First, key informant interviews were conducted around the time of CRP implementation and at project end with individuals identified by site leaders as important to the success of the CRP. We recruited at least two respondents per facility, plus Insurer representatives who worked with each of the five sites where physicians covered by Insurer practiced. Interviews lasting 30–45 minutes were conducted by phone by one or two academic researchers using a semistructured interview guide. Interview transcripts

were analyzed by one researcher using standard methods of thematic content analysis.

Second, detailed notes on implementation progress were kept during meetings among project staff and between project staff and site leaders. Meeting notes were supplemented by notes from a project consultant hired midway through the study period to monitor and support CRP operation.

Third, risk or claims representatives at each site were asked to prospectively enter data on each CRP case into an online database. These data included detailed information about the nature of each incident, communications with patients, collaborations with other facilities and insurers, and resolutions.

LIMITATIONS

Our evaluation was limited by our inability to directly observe the CRP in action at each site. Additionally, risk and claims representatives reported that heavy workloads prevented them from completing the requested data collection for all cases to which they applied the CRP. Consequently, only 30 events are represented in the study database, limiting its utility as a source of information about implementation and making it difficult to verify some information reported in interviews. Finally, interview responses may reflect self-serving bias, conscious, or unconscious. As a check on such bias, we compared interview responses to information gleaned from meeting notes.

RESULTS

Interview Sample Characteristics

Interviews were completed for 46 of 50 invitations sent (92 percent)—23 at baseline and 23 at project end (Table 1). Respondents were facility clinical leaders, facility-based risk managers, facility-based claims representatives, and insurance company claims representatives and administrators (Table 2). The interviews involved 26 different individuals, 20 of whom were interviewed twice. Three baseline respondents were not reinterviewed: two who had left the facility and one who did not respond to our interview request. Three end-of-project respondents were not among the baseline respondents: one who did not respond to our baseline invitation, one who joined the

Table 2: Roles of Interview Respondents

<i>Role</i>	<i>Number of Individuals Interviewed</i>	
	<i>Baseline</i>	<i>End of Project</i>
Facility clinical leaders	7	7
Facility-based risk managers	6	5
Facility-based claims representatives	3	3
Insurance company claims representatives and administrators	7	8

organization during the study, and one who became more involved with the CRP than anticipated.

Implementation Experiences

Descriptions of each organization’s CRP implementation journey are provided in the Appendix SA2. Here, we summarize the group’s experiences.

Practices before CRP Implementation. At baseline, respondents consistently reported that the facilities had strong relationships with Insurer, though one relationship had been marred by some adverse experiences trying to resolve claims. Many key individuals at the facilities and Insurer had long worked together. The facilities’ relationships with one another were more variable. Among some, distrust had arisen in past cases.

The sites all began the project with gaps between their practices and the CRP Key Elements. Facilities A2, A3, B, and D reported suboptimal levels of adverse event reporting, disclosure, and follow-up with patients about investigation findings. Facility A1 reported satisfaction with the consistency and timeliness of reporting but struggled with disclosure and feedback to patients, while Facility C reported satisfaction with its disclosure, reporting, and feedback practices. At all facilities, risk managers’ investigations focused on events drawn from patient complaints or claims and other events involving clear error and serious harm.

Facilities A2, A3, B, and D had no prior history of making proactive offers of compensation before the patient had requested it, beyond offers of “service recovery” items such as waiving medical bills and covering modest out-of-pocket expenses. The other two facilities made proactive offers occasionally.

Insurer representatives believed their organization had long applied the CRP approach and welcomed the opportunity to make it a collaborative effort. Yet the degree to which claim representatives actually practiced proactive compensation at baseline varied. Some said that, when notified of an adverse event, they rarely initiated discussions about compensation until the patient demanded it.

Insurer representatives hoped the CRP would improve the timeliness with which they were notified of incidents by the facilities and their insured physicians, which they believed would allow them to be more proactive. They also desired a more collaborative relationship with the hospitals, some of which, they reported, tended to call Insurer only after they had reached a decision about how an incident should be resolved.

At all sites, organizational leaders were consistently described as strongly supportive of the CRP. However, none of the top leaders were actively working to champion the program within their organizations. Another commonality among all sites, regardless of their size, was that their risk and/or claims departments were reportedly understaffed. Although some sites received few malpractice claims, risk management offices' resources were strained because they were responsible for a broad range of other matters.

Results of CRP Implementation. Facility A1 implemented the CRP Key Elements and applied the process to adverse events to a far greater extent than the other facilities. A “gung ho” risk manager who believed deeply in the concept assertively promoted and used it, with the support of strong, engaged physician champions within the hospital. New disclosure training and “care-for-the-caregiver” programs were well received. Respondents perceived improvements in disclosure and reporting, although they partially credited other forces within the hospital for these changes. To a greater extent than other facilities, the Risk office at Facility A1 was able to protect resources to carry out the increased work of the CRP. It was also able to quickly develop concrete protocols for implementing the CRP, whereas this took place slowly, or not at all, at other organizations.

Facility A1's success in resolving events through the CRP came easier for purely internal incidents than for events involving other organizations. The CRP strengthened its already good relationship with Facility D, and the

organizations agreed on detailed protocols for collaborating to investigate and resolve events. The CRP also wrought improvements in Facility A1's relationship with Insurer. The organizations worked diligently to resolve disputes and address distrust—for example, convening a meeting at which they established a set of guidelines for what to do when they encountered disagreement working together on a shared case. However, this progress was undercut by missteps in a serious-harm case near the end of the study, which “put a sour taste in everyone's mouth.”

Other facilities reported that the CRP helped them improve and “systematize” disclosure and reporting at their facilities. They specifically credited educational sessions for physicians about the CRP, disclosure training, and support services for clinicians involved in adverse events as having reinforced their efforts to promote a culture of transparency. They also reported that their Risk offices had made feedback of investigation findings to families more routine.

However, these facilities actually applied the CRP process in only a handful of cases, and they did not consistently provide the case-level data that could have enabled us to verify their characterizations of how these cases went. The smaller facilities reported that they had not experienced any events that they felt were appropriate to put through the process—for example, because the harms were not serious enough or they had not experienced any events involving Insurer or other organizations. Other sites had serious events, but they felt those events were too high-stakes to test a new process on, or they felt a general reluctance to be first among the sites to initiate the CRP. “No one,” one respondent said, wants to be the one “at the pointy end of the stick.” Facility C spent considerable time developing a formal CRP policy and obtaining approval from its board of directors, leaving little time in the study period to apply it.

Sites did report “rewarding” experiences in applying the CRP once they finally dove in—typically in cases that did not involve another organization. Disclosure conversations went well; they were successful in increasing the speed of their investigation and communicating more fully and consistently with families afterwards; and they were able to successfully resolve a number of events with explanations, apologies, and offers of service recovery. Buoyed by these successes, they remained enthusiastic about the CRP as an internal process.

Except for Facility A1, organizations did not indicate that their compensation practices had changed under the CRP. Some respondents seemed not to appreciate the distinction between quickly settling claims

where liability was clear—their preexisting practice—and proactively offering compensation before claims were filed. Others observed that certain claims representatives were too set in their ways to change, particularly as the new approach involved doing extra work and initiating difficult conversations about the need for disclosure with distressed and reluctant clinicians.

Implementation Barriers Encountered

Distant Support from Leaders. Each organization had one or more high-level leadership “champions” of the CRP identified at the outset of the project, often the chief medical officer. Although end-of-project interview respondents consistently described these leaders as strongly supportive of the CRP throughout the project, the leaders reportedly were not “out front championing it.” Their support was passive, not active.

Many of the leaders were described as overburdened with responsibilities. “He’s really stretched,” said one risk manager about her CMO; “he’s so fragmented with all his responsibilities that he can’t concentrate on it,” remarked another. Some leaders grappled with other major organizational initiatives, such as acquisition of new hospitals and group practices, during the project period. Competing priorities outranked the CRP in capturing their attention and effort.

Without the active engagement of “the heavy hitters,” it was difficult to promote the CRP effectively to physicians. “It has to be physician to physician” to drive culture change, one respondent observed. Frontline risk and claims representatives felt well supported in principle in carrying out the work of the CRP but received no additional staffing to help relieve workload pressure. Furthermore, at Insurer, top leaders, though supportive, did not intervene to address a gulf in the attitudes of frontline claims representatives toward the CRP. Some claim representatives worked energetically to apply the CRP to their cases, while others largely disregarded it.

Distrust. The seven organizations involved in the project started off with a high level of commitment to improving their relationships with one another. But they had difficulty overcoming distrust stemming from past cases they felt had been mishandled. When blunders occurred in the handling of new cases, old feelings flared. Some sites developed detailed protocols for collaborating more effectively, but they perceived that their partners disregarded these

guidelines in important cases. Difficulty transcending these feelings dampened enthusiasm for collaboration going forward.

Consent-to-Settle Provisions in Insurance Contracts. Several respondents commented that physicians' unwillingness to participate in disclosure and/or early settlement had been a barrier in CRP implementation, and they traced this to the terms of Insurer's contract with their physicians. These contracts contain a "consent-to-settle" provision allowing the insured physician to decide whether to offer a settlement. Some physicians were unwilling to do so, primarily because of concern about the consequences of having the payment reported to the state board of medical licensing or the NPDB. Physicians reportedly perceived the state board as "aggressive and unpredictable" and feared action against their license. Respondents perceived that Insurer did not push back when physicians indicated they would rather wait to see if the patient sued. Insurer was committed to maintaining its consent-to-settle policy and mindful that, as a physician-owned mutual company, its primary obligation was to its physicians. Thus, whereas an academic medical center that employs and insures its physicians has both the leverage and the incentive to bring physicians into the fold when it comes to proactively negotiating settlements, Insurer faced both structural and philosophical obstacles to doing so.

Insurer's Distance from the Point of Care. A simple problem inhibited Insurer's ability to carry out the CRP: claims representatives could not get timely access to patients' medical records. They first had to secure the patient's written authorization, which could take weeks or months. Additionally, without "boots on the ground," Insurer was reliant on the facilities and its insured physicians for notification about incidents. It continued to experience problems with delayed notification from its physicians. Hospital risk managers, too, sometimes did not reach out as they were supposed to (often believing that the physician had contacted Insurer or that they should not interpose themselves in the Insurer-insured relationship).

Staff Turnover. At two facilities, key members of the Risk/Quality team left just as the CRP was about to launch. The gap created by their departure, it was felt, doomed the program. The new hires had not been part of the process of developing the CRP and had little buy-in. They were presented with a mandate to

implement the CRP, but no real implementation plan or resources with which to do so. Competing priorities drew their attention elsewhere. Similar disruptions occurred at several facilities when their chief medical officers—crucial allies in promoting the CRP to physicians—turned over.

Workload. Sites uniformly reported that inadequate staffing in risk and claims management was a barrier to more extensive implementation and application of the CRP. Few sites allocated new resources to the CRP; respondents noted that resources for “administrative costs that don’t generate revenue” are “limited.” Although sites indicated concern about workload at baseline, they underestimated the extent to which the CRP would demand additional time and effort. The CRP Key Elements seemed consistent with their existing practice, but in reality involved more phone calls and meetings with families, clinicians, insurers, and external organizations; compressed investigation timelines; and follow-up on more reported events. One respondent said, “we felt like this was already our culture, . . . [but] we weren’t fully aware of what *this* was.” The CRP also meant devoting more attention to less urgent matters, such as events that did not involve blatant error or an angry family. For already-stretched risk managers, any added work not related to the goal of resolving pressing problems can be difficult to justify.

One concrete result of the workload problem was that conducting educational outreach—for some facilities, to hundreds of nonemployed physicians—was viewed as difficult or impossible. Another was that risk and claims representatives found themselves unable to investigate every event meeting the CRP eligibility criteria. They continued to prioritize “the ones that are on fire”: serious-harm events involving error or complaints from families. At most institutions, it is a significant culture change to widen the risk management lens to consider what steps should be taken in response to other events. Project staff emphasized that all events are important to review because they may suggest opportunities to improve care and prevent future malpractice claims. Participants understood this, but they lacked the bandwidth to expand their activities.

Distractions. Each site coped with major institutional changes, such as budget cuts, practice acquisitions, new regulations, and new electronic records systems, during the study. Overburdened risk managers were called upon to play a major role in these initiatives, which made it difficult for them to keep the

details of the CRP—such as which events were eligible for inclusion and how to record data—in the foreground. Risk managers have a fluid job description and are constantly pulled into diverse matters unexpectedly, leaving them in crisis mode much of the time. This works against the expansive, proactive surveillance and investigation that the CRP involves.

Lack of a Clear Implementation Plan with Assigned Roles and Responsibilities. Although sites completed the implementation workbook, which created a high-level list of steps needed to implement the CRP, it was rare for them to follow-up by creating implementation teams and concrete plans for bridging gaps between their existing practice and the CRP Key Elements. Consequently, at some sites, little changed.

Overall Impressions

Overall, at the end of the project, participants characterized CRP implementation as challenging within organizations and “very, very difficult” across organizations. Yet respondents were strikingly upbeat about the prospects for CRPs to succeed in an open setting. They viewed their enterprise as a first attempt that had encountered both predictable and unforeseen barriers and produced lessons on which they and others could build. While cautioning that organizations with a history of distrust were unlikely to succeed in a collaborative CRP without a steadfast commitment to letting go of historical grievances and tolerating bruises going forward, they encouraged others to try.

With regard to workload, they expressed the view that operating a well-implemented CRP was worthwhile, because “if we do this right, it actually avoids a lot of wasted work.” That is, although there are substantial up-front costs in terms of revamping policies and procedures and doing more outreach to clinical staff and families, over the longer term, effort is shifted away from defending cases that should not be defended. For some risk managers, however, this optimism was out of step with their actual behavior: the prospect of long-term efficiencies did not overcome barriers to changing their time allocation.

Respondents offered several concrete suggestions for future attempts to implement CRPs within and across organizations (Box 2). Many of these recommendations focus on strategies for building and maintaining trusting relationships among organizations. However, many echoed recommendations for successful internal implementation that have emerged from academic medical

Box 2: Project Sites' Advice for Other Organizations Implementing CRPs

- Start by taking an inventory of potential obstacles to successful collaboration with other organizations, including trust problems; then address them openly in one or more face-to-face meetings.
- Develop detailed protocols inside your organization and with external organizations concerning notification of adverse events, communication, and resolution. Ensure that they include timelines, assign specific responsibilities to specific individuals, and specify a mechanism for ensuring that external organizations get timely access to medical records.
- Ensure that the impetus for and driving force behind the program comes from top leaders at the facility and insurer, especially physician leaders. "It has to be physician to physician" to drive culture change.
- Allocate adequate resources in risk and claims management to operate the program. For most organizations, this will be an additional 0.5 to 1.0 full-time equivalents.
- Do not launch the CRP until the key supporting pillars are in place, including physician education, care-for-the-caregiver services, communication protocols, and a system for tracking the progress of events through the program.
- Recognize that insurers with consent-to-settle provisions may be hampered in their ability to offer proactive compensation. Obtaining physician buy-in through educational outreach is essential to minimize this barrier.
- Maintain open communication about relationship problems, be prepared to forgive missteps, and do not "haggle over pennies."
- Negotiate from your insurer or facility leaders a modest pool of money (e.g., \$10,000 per incident) that can be used at risk managers' discretion to resolve small matters without having to initiate a formal process of joint resolution with other organizations.
- Implement a CRP as part of a group of organizations that meet regularly to share experiences, including success stories and implementation barriers.
- Expect it to take time to build trust across organizations, which arises through successful experiences working together. Give it at least 5 years before you judge the CRP a success or failure.

centers and other early adopters of single-institution CRPs (Mello et al. 2014a,b), including ensuring active engagement from clinical leaders and adequately resourcing the Risk office.

CONCLUSIONS

We found that although our project sites experienced some victories resolving particular cases and improving working relationships, they encountered several barriers to successful CRP implementation in the open setting that they were unable to surmount. Sites embarked on their initiative with greater enthusiasm than their counterparts in the New York demonstration project and implemented their programs in a less volatile medical liability

environment after a much longer process of collaborative development of CRP Key Elements. Yet their results were, by and large, similar to the outcomes in New York, and they experienced many of the same challenges. These included difficulties reaching physicians to educate them about the CRP; unwillingness on the part of a minority of physicians to participate in early settlement due to fears of provoking claims and reports to regulatory bodies; bandwidth problems among persons tasked with CRP implementation; and organizational leaders who did not personally promote the program (Mello et al. 2014b). These issues may affect other new adopters of CRPs unless organizations take active steps to avoid them.

Our overall conclusion is that operating CRPs in which two or more organizations must collaborate to resolve cases can be highly challenging and likely requires several preconditions not present for our sites, including persistent, visible engagement by top leaders, a commitment from physicians to collaborate with facilities to resolve incidents, effective mechanisms for quickly transmitting information to remote insurers, tolerance for missteps in early attempts at collaboration, clear protocols for joint investigations and resolutions, and an understanding that culture change occurs, as one participant put it, “at glacial speed.” The small successes our sites had in implementing the CRP, coupled with the enduring enthusiasm most respondents had for the approach notwithstanding some adverse experiences, suggests that the collaborative CRP approach merits further testing. The limited success of this early experiment could relate to distinctive features of the project design or participating organizations.

It is clear that rapid scale-up of the model without adequate supports for and within the implementing institutions is not prudent. The new AHRQ-sponsored CRP implementation toolkit (Agency for Healthcare Research and Quality 2016) should help newcomers avoid the “flying in the dark” feeling our sites had when it came to the nuts and bolts of program implementation.

The Washington State experience confirms findings from New York that CRPs are unlikely to succeed when the primary force pushing their implementation comes from outside the organization. Although support for the CRP within project sites was strong, top leaders adopted a posture of passive endorsement rather than active engagement. The project team had limited ability to influence sites to change practices to improve alignment with the CRP Key Elements. Attempts to encourage such movement sometimes encountered resistance from staff with different priorities. The lesson learned is that while external consultants can provide valuable support to new CRP

adopters, it is critical that institutions closely examine whether their own leadership is sufficiently energized around the idea that one or more leaders will make it his/her personal cause for an extended period of time.

To stimulate intrinsic motivation for CRP participation among facilities and physicians, the project team and key stakeholders are currently working with the medical licensing board in Washington State, known as the Medical Commission, to pilot a modified Medical Commission response to reported adverse events. In the pilot, known as CRP Certification, the Medical Commission intends to close medical error cases that go through the full CRP process as adequately resolved, while maintaining its authority to impose discipline when required (Gallagher et al. 2016). This approach could help address providers' fears that reporting and disclosing adverse events will trigger disciplinary action.

The more researchers and health care institutions learn about CRPs, the more apparent it becomes that executing this seemingly simple idea well is complex. The complexity only grows as the constellation of organizations operating interactive CRPs expands. Yet CRPs, whether collaborative or single-institution, are highly worthy of continued testing. The experience of pioneering institutions shows that when done right, the model is powerful—and no other medical liability reform approach holds as much promise for improving safety. Collaborative cases require extra attention to developing shared commitments, joint processes, and trust. Exporting the early adopters' success to that context and other new settings requires engagement from top to bottom in culture change to support the CRP approach, which in turn requires heeding lessons learned—including those from Washington State.

ACKNOWLEDGMENTS

Joint Acknowledgment/Disclosure Statement: This project was supported by grant no. R18HS019531 from the Agency for Healthcare Research and Quality (AHRQ). The content is solely the responsibility of the authors and does not necessarily represent the official views of AHRQ. The authors acknowledge with gratitude the dedicated efforts of staff at the participating health care facilities and insurer to implement the program and provide data for the evaluation. We also thank Lauren Lipira, Amelia Chappelle, Ben Dunlap, and Aurora DeMattia for project support.

Disclosures: None.

Disclaimers: None.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.

Appendix SA2: Supplemental Information on Project Participants.