Case Outcomes in a Communication-and-Resolution Program in New York Hospitals

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Objective. To determine case outcomes in a communication-and-resolution program (CRP) implemented to respond to adverse events in general surgery.

Study Setting. Five acute-care hospitals in New York City.

Study Design. Following CRP implementation, hospitals recorded information about each CRP event for 22 months.

Data Collection Methods. Risk managers prospectively collected data in collaboration with representatives from the hospital's insurer. External researchers administered an online satisfaction survey to clinicians involved in CRP events.

Principal Findings. Among 125 CRP cases, disclosure conversations were carried out in 92 percent, explanations were conveyed in 88 percent, and apologies were offered in 72.8 percent. Three quarters of events did not involve substandard care. Compensation offers beyond bill waivers were deemed appropriate in 9 of 30 of cases in which substandard care caused harm and communicated in six such cases. In 44 percent of cases, hospitals identified steps that could be taken to improve safety. Clinicians had low awareness of the workings of the CRP, but high satisfaction with their experiences.

Conclusions. The bulk of CRPs' work is in investigating and communicating about events not caused by substandard care. These CRPs were quite successful in handling such events, but less consistent in offering compensation in cases involving substandard care.

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

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In New York State, a volatile liability environment with few tort reforms, there has been keen interest among health care providers in identifying feasible, effective pathways for reducing medical liability risk. In 2009, five New York City hospitals signed on to participate in a demonstration project of communication-and-resolution programs (CRPs) funded by the Agency for Healthcare

Research and Quality (AHRQ). Working with the New York State Department of Health and academic researchers, the hospitals collaboratively designed and implemented a CRP.

The key elements of the CRP, hospitals' practices before implementing it, and details regarding its implementation have been described elsewhere (Mello et al. 2014a). In brief, the CRP shared with its predecessor, the University of Michigan Health System model (Boothman et al. 2009), several features: providers should promptly report adverse events to the hospital and disclose them to patients; risk managers should conduct a timely investigation, working with experts and personnel within and outside the Risk department to make determinations about what occurred; findings should be routinely conveyed to patients; compensation and apology should be offered proactively where it is determined that substandard care caused harm; and each event should be scrutinized for patient safety lessons. Unlike Michigan, the New York City hospitals elected to limit the CRP to serious adverse events (AHRQ Harm Scale rating of "temporary, severe" or greater) and pilot it in the General Surgery department only. General Surgery was chosen because it experienced frequent malpractice claims, but the cases tended to have lower complexity and damages than adverse events in other high-claims areas. Each hospital provided training to surgeons on the CRP and disclosure skills.

The CRP was implemented in 2010 and evaluated over its first 22 months. We report the characteristics and outcomes of 125 cases of harm handled by the CRP during that period, along with the results of a survey of clinicians involved in those cases. Our findings illuminate some of the challenges of disseminating the CRP approach beyond the hospitals that pioneered it, which report great success in improving communication and reducing liability costs (Kraman and Hamm 1999; Boothman et al. 2009; Kachalia et al. 2010; Kachalia and Mello 2011; Mello et al. 2014b; Grenon et al. 2015).

SETTING

Five not-for-profit, nongovernmental, general acute-care teaching hospitals in New York City participated. Two were medium-sized (500–999 beds) and

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three were larger. One is insured for professional liability by a shared captive insurer. The others obtain insurance and risk- and claims-management services from a risk-management organization owned by its client facilities.

In adopting CRPs, hospitals sought to foster more complete and timely internal reporting of adverse events; improve the consistency and quality of disclosure communications; expedite event investigations; communicate findings to families routinely; and expand use of proactive compensation offers, which they had tended to make only in exceptional cases. Further details about the implementation of the CRP are available elsewhere (Mello et al. 2014a).

STUDY METHODS

Risk or claims managers at each hospital were asked to prospectively record data on each case meeting the study criteria in a database on the REDCap electronic data capture platform (Harris et al. 2009). Data fields spanned the injury and surrounding circumstances, the patient and involved providers, the progress of cases through each step in the CRP process, and case outcomes. Information on whether cases resulted in claims or lawsuits was updated 38 months after the study period ended, after the statute of limitations for filing claims had expired (except for 1 hospital, which only provided an update at 15 months).

To assess clinicians' satisfaction with the CRP, a 15-item, online survey was sent to the clinician who risk managers identified as having been most involved with the CRP case. Structured survey questions elicited clinicians' familiarity with the CRP, satisfaction with their communications with the patient/family, and perceptions of the fairness of the CRP process, the helpfulness of program representatives, and the usefulness of the program in helping avoid a malpractice claim. Patients and family members were not surveyed because the hospitals declined the study team's invitation to do so. The project was approved by the institutional review boards of the Harvard School of Public Health, Stanford University School of Medicine, and the New York State Department of Health.

RESULTS

Data were collected on 125 CRP events. The sample included 23 events outside General Surgery, because three hospitals elected to apply the CRP to

other cases. Survey invitations were sent to 124 clinicians (for one case, a survey was not sent because the clinician was reportedly emotionally fragile in the wake of the incident). One invitation was undeliverable, and surveys were received from 70 of the remaining 123 clinicians (56.9 percent).

Case Characteristics

Patients in CRP cases were, on average, 55 years old and 54 percent had severe systemic disease (Table 1). Eighty-two percent of events were first reported to the Risk Management or Quality office by clinicians. Only 7 percent were emergency cases.

Most injuries (70 percent) involved temporary, severe harm as defined by the AHRQ Harm Scale. Fifteen percent were deaths, 12 percent involved permanent harm, and the remaining 5 percent involved more minor harm. In 14 percent of cases, the patient or family complained before or during the CRP process that the care was substandard.

Timeliness of the CRP Process

The initial report of the adverse event to Risk Management or Quality was made within 24 hours for 25 percent of events. Half the events were reported within 6 days and 75 percent within 18 days. The median time to complete the CRP investigation was 39 days (interquartile range (IQR) [15, 94]).

The time elapsed between the first communication with patients or families about the adverse event and the last communication was typically short: 25 percent consisted of one or more conversations in the same day, and 50 percent were concluded within 2 days. In three quarters of cases concluded within 2 days, risk managers found the standard of care had been met. Seventy-five percent of communications were concluded within 32 days, while a small minority stretched considerably longer.

Communications about the Harm Event

An initial disclosure conversation with the patient/family—which typically conveyed that an adverse outcome had occurred, information known at the time about why, and the implications for the patient's care—was documented for 92 percent of cases. The remaining 10 cases were retained in the analytical sample because they received other CRP elements. Half these cases were explained as involving circumstances that precluded an initial disclosure from

Table 1: CRP Case Characteristics ($n = 125$)

	<i>n (%)</i>
Hospital	
1	22 (17.6)
2	20 (16.0)
3	17 (13.6)
4	41 (32.8)
5	25 (20.0)
Severity	
Death	19 (15.2)
Permanent harm – severe	6 (4.8)
Permanent harm – not severe	9 (7.2)
Temporary harm – severe	86 (68.8)
Temporary harm - not severe	3 (2.4)
Emotional distress only	2 (1.6)
Adverse outcome	
Altered medical management	71 (56.8)
Prolonged hospital stay	65 (52.0)
Death	19 (15.2)
Hospital admission	16 (12.8)
Disability	14 (11.2)
None of the above	4 (3.2)
Clinical event*	
Unintended laceration or puncture	23 (18.4)
Anastomotic leak/enterotomy	21 (16.8)
Bleeding requiring return to operating room	13 (10.4)
Unintended blockage, ligation, or obstruction	12 (9.6)
Surgical site infection	11 (8.8)
Dehiscence, flap or wound failure or disruption, or graft failure	10 (8.0)
Retained foreign body	9 (7.2)
Cardiac/respiratory arrest	7 (5.6)
Unplanned removal of organ	6 (4.8)
Incorrect operation or procedure	6 (4.8)
Bleeding intraoperatively	4 (3.2)
Other	9 (7.2)
Patient	
Male	61 (48.8)
Age (mean, SD)	55.3 (16.9)
Married	51 (40.8)
Health insurance	
Private	67 (53.6)
Medicare	35 (28)
Medicaid	36 (28.8)
Other	9 (7.2)
Not documented	1 (0.8)
Emergency case	8 (6.4)

Continued

Table 1 *Continued*

	<i>n (%)</i>
ASA Physical Status Classification System class	
1: normal healthy patient	10 (8.0)
2: mild systemic disease	44 (35.2)
3: severe systemic disease	46 (36.8)
4: severe systemic disease, constant threat to life	21 (16.8)
Not documented	4 (3.3)
Patient/family alleged standard of care was violated	18 (14.4)
Primary involved clinician	
Attending physician	116 (92.8)
Resident/fellow	3 (2.4)
Anesthesiologist	2 (1.6)
Registered nurse	2 (1.6)
Radiologist	1 (0.8)
Not documented	1 (0.8)
First reported to risk management by	
Involved clinician	41 (32.8)
Uninvolved clinician	61 (48.8)
Patient/family	6 (4.8)
Patient Services	6 (4.8)
Peer-review process	4 (3.2)
Quality-improvement process	2 (1.6)
Detected on chart review	2 (1.6)
Other	2 (1.6)
Not documented	1 (0.8)

*Categories are not mutually exclusive.

being feasible—for example, the harm was not known until the patient reported symptoms weeks after discharge, or the patient was not competent or conscious and had no family. Communication of the fact that an adverse event occurred was documented in 99 cases (79.2 percent). The remaining cases were typically characterized as involving “known complications” which, though discussed with the patient or family, were not considered adverse events because they were not unexpected.

The involved clinician participated in 93.9 percent of initial disclosure conversations. In the other cases, participants included senior uninvolved clinicians (i.e., the chief of surgery), risk-management or quality personnel, and one insurer representative. An explanation of why the harm occurred was communicated in 110 cases (88 percent). An apology of sympathy was communicated in 80 cases (64 percent) and an apology of responsibility was given in 16 cases (12.8 percent of all cases).

Liability Determinations

Two-thirds of cases (81/125, 65.9 percent) were judged to involve injuries causally related to medical management (Figure 1). Three-quarters (93/125, 74.4 percent) were judged not to involve a violation of the standard of care. Twenty-four percent of events were determined to involve all of the essential elements of a negligence claim: an injury, causation, and substandard care. Rating their confidence in these judgments along a six-point scale, CRP decision makers in Risk or Quality departments selected “virtually certain” or “moderate to high confidence” in 73.6 percent of cases for causation and 77.6 percent for standard of care.

Compensation offers were determined to be appropriate in only about 30 percent of the 30 cases in which a standard-of-care violation caused harm (Figure 1). Compensation offers were also deemed appropriate as a “compassionate gesture” in two cases in which no standard-of-care violation occurred. Offers to waive medical bills were determined to be appropriate in a total of 19 cases, including 12 in which the standard of care was violated. Apologies were selected as an appropriate resolution element more commonly than financial remedies.

Figure 1: Resolution Determinations and Communications in CRP Cases ($n = 125$)

Some discordance was observed between resolutions deemed appropriate and those actually communicated to patients and families, particularly for financial remedies (Figure 1). In cases in which the standard of care was violated, compensation offers were actually made in 6 of the 9 cases in which they were deemed appropriate, and bill waiver offers in 7 of 12 cases. Compensation offers ranged from \$8,000 to \$1.25 million.

Risk managers' free-text notes explained some of the discrepancies. Bill waiver offers were not communicated when it was discovered that there were no out-of-pocket expenses to waive. In five cases, compensation offers were not made because the patient/family did not respond to repeated outreach attempts from the hospital or asked representatives to stop calling. In four cases, the hospital perceived patients to be satisfied with the disclosure and explanation they received, and felt that if they wanted to pursue compensation, they would ask. In three cases, the physician was not a hospital employee and carried separate insurance; the hospital felt that responsibility rested with him/her. In one case, the CRP process reportedly terminated when the patient retained an attorney, presumably because the attorney declined to participate. In the remaining cases, no explanation for not offering compensation was documented. Many, though not all, of these were cases in which the hospital had low confidence in its judgment that the harm was caused by a standard-of-care breach or did not consider the harm serious.

Claims and Lawsuits Filed

By the final update, 21 CRP cases (16.8 percent) had resulted in a lawsuit being filed and another six (4.8 percent) had a claim (written demand for payment) asserted but no lawsuit filed. Three cases (2.4 percent) were settled with a release of claims signed prior to litigation being filed, consistent with the CRP's objective of early settlement. The remaining cases (65.6 percent) did not result in a claim or lawsuit although the institution had not settled them through the CRP.

We examined the CRP determinations made in the 27 cases that resulted in a claim or lawsuit. Half (13 cases) involved a standard-of-care violation and causation, while the rest were judged to lack legal merit. The hospital had only offered compensation in 4 of the 13 meritorious cases.

The 14 nonmeritorious claims and suits represented several scenarios. In half, there was no sign that the family was dissatisfied with the communications made by the hospital. In three, there were problems in the communication process (for example, the surgeon told the patient he made a mistake but

the hospital investigation concluded otherwise). In two cases, the family stopped speaking with the hospital. In the other two, after multiple conversations the family still disagreed with the hospital's judgment that the care was not substandard.

Patient Safety Findings

The types of errors identified by CRP investigations were diverse (Table 2), with no one type implicated in a large number of cases. Among the many

Table 2: Patient Safety Findings in CRP Cases

	<i>n (%)</i>
Errors (denominator: all 125 cases)	
Inadequate pre- or postoperative monitoring or management	7 (5.6)
Incorrect surgical count	7 (5.6)
Wrong procedure or wrong side	5 (4.0)
Unintended injury to surrounding organs	4 (3.2)
Medication error	3 (2.4)
Device or equipment related	2 (1.6)
Anesthesia related	2 (1.6)
Other	10 (8.0)
Safety improvements likely to be implemented (denominator: all 125 cases)	
Input into internal quality improvement system for ongoing analysis	55 (40.0)
Educational efforts	24 (19.2)
Findings shared with involved staff	22 (17.6)
Policy changes	11 (8.8)
Safety alert sent to staff	3 (2.4)
Human factor engineering analysis	3 (2.4)
Other	6 (4.8)
None	56 (44.8)
Human factors most frequently implicated in standard-of-care violations (denominator: 30 cases of standard-of-care violations)	
Communication among staff members or team	17 (56.7)
Inattention	13 (43.3)
Culture of safety/management	6 (20.0)
Competence	6 (20.0)
Training	6 (20.0)
Clarity of policies	6 (20.0)
Clinical supervision of staff	5 (16.7)
Presence of policies	5 (16.7)
Availability of data	5 (16.7)
Contributors to standard-of-care violations (denominator: 30 cases of standard-of-care violations)	
Systems failures only	4 (13.3)
Failures of individual provider(s) only	11 (36.7)
Both	15 (50.0)

human factors that contributed to standard-of-care violations, two predominated: intrateam communication problems (17 cases, 56.7 percent) and inattention (13 cases, 43.3 percent). Nearly all standard-of-care deviations (86.7 percent) involved a failure of an individual provider; 50 percent also involved a system failure.

The majority of cases (56 percent) did not suggest avenues for safety improvement; these were generally cases in which the event was deemed unpreventable (Table 2). For other cases, risk managers frequently referred the event to the hospital's quality-improvement process for ongoing analysis and/or communicated feedback to involved clinicians. However, a few cases suggested a need to change a policy (11 cases, 8.8 percent) or issue a formal safety alert (3 cases, 2.4 percent).

Clinicians' Perceptions of the CRP

Most clinicians who responded to the satisfaction survey had low awareness of the CRP (Table 3). Nearly all reported that they did not know what, if anything, the program had given the patient as compensation or how long it had taken to resolve the case. Most respondents skipped survey items relating to their interactions with CRP representatives or indicated that they had no such interactions, suggesting low levels of contact between CRP staff members and involved physicians.

Clinicians' satisfaction was high (median score above 85 on a 100-point scale) for items concerning disclosure conversations and, when they occurred, interactions with CRP representatives. Clinicians also perceived the program to have treated them fairly (median 75, IQR [50, 99.5])—and, to a somewhat lesser extent, to have treated the patient and family fairly (median 58, IQR [50, 97]). Ratings for the perceived likelihood that the program had helped avoid a lawsuit were weaker (median 50, IQR [25, 59]). Comments consistently indicated the reason for low ratings was that the clinician did not believe the incident would have triggered a lawsuit even without the CRP, because the harm was not severe or preventable.

Limitations

Our study has limitations. First, for a few events, we could not obtain updated information from the hospital on whether a claim or lawsuit was ultimately filed. Second, our data from five hospitals may not generalize to other organizations. Research suggests that health care organizations differ in how—and how

Table 3: Clinicians’ Satisfaction with Their CRP Experience*

Question	n	Median Score [IQR]
How satisfied were you overall with the conversations with the patient and/or patient’s family about what happened?	54 [†]	85.5 [64, 95]
How satisfied were you with the assistance you received from Program representatives in preparing for the disclosure conversation(s)?	24 [‡]	87.0 [29, 99]
Overall, how satisfied were you with your interactions with Program representatives?	24 [§]	89.5 [65, 99.5]
Overall, how fairly did Program representatives treat your patient and/or patient’s family?	56	58.0 [50, 97]
Overall, how fairly did Program representatives treat you?	56	75.0 [50, 99.5]
How likely do you think it is that the Program helped you avoid a lawsuit?	57	50.0 [25, 59]

*Survey respondents gave ratings by sliding a marker along a visual scale from 1 (extreme negative) to 10 (extreme positive). The REDCap Survey system reported marker locations on a scale from 1 to 100. Medians and interquartile ranges (IQR) are reported in the table. For each item, *n* represents the number of completed responses received for that question, out of a total of 70 surveys returned with at least some items completed.

[†]Of 62 respondents who said they personally participated in a disclosure conversation with the patient or family.

[‡]Nonresponders to this question may not have received any assistance in preparing for disclosure.

[§]Nonresponders to this question may not have had any direct interactions with Program representatives.

fully—they implement CRPs (Mello et al. 2014a, b, 2016), which could lead to differences in outcomes. Moreover, our sample was predominantly General Surgery cases. Other types of events may be more (or less) difficult to resolve.

DISCUSSION

This report provides the first in-depth look at the dynamics of event resolution within CRPs. Through detailed examination of the progress of a fairly large sample of events through CRPs in five hospitals, our analysis illuminates some of the practical issues that contribute to both the successes and the shortcomings of CRPs in the AHRQ demonstration projects (Mello et al. 2014a, 2016). Several findings merit emphasis.

Discordance between CRP Determinations and Offers Made

In cases involving standard-of-care violations, our hospitals had difficulty adhering to the principle that compensation should always be proactively

offered. We observed considerable discordance between standard-of-care and causation determinations on the one hand, and what was offered to patients on the other, although the former should have driven the latter. Often, no reason for this divergence was documented. Hospitals simply appeared to prefer to offer lesser remedies such as bill waivers and apologies and wait for the patient to voice interest in compensation.

In some cases, that preference may reflect the short-lived impact of the harm or difficulties encountered in assessing the extent of the harm within the timeframe of the CRP process. More broadly, our earlier interview study linked that posture to worries that offering compensation would trigger escalating demands, potentially culminating in litigation (Mello et al. 2014a). There was also a reluctance to offer money where the patient seemed not to be interested in it.

Yet, not offering compensation in such cases undermines the principle-driven approach of CRPs and creates inequities among similarly situated patients based on how aggressive they are in demanding compensation. Moreover, feelings of anger or trauma may develop later, after the patient/family has had time to process the event, and may find an outlet in litigation.

In many cases in our sample, there were other, understandable reasons why hospitals did not deliver compensation offers. For example, patients and families did not show up to meetings or return calls, or retained attorneys who were not willing to engage with the hospital. However, the early resolution process need not end with the filing of a lawsuit, and may even be enhanced by the involvement of an attorney.

While more could be done to ensure continuity of process after an attorney enters the picture, it is also true that the CRP process will not appeal to every patient. Some may be too angry to engage, or may prefer to seek higher compensation through a lawsuit. Leaders of even the most successful programs, such as Michigan's, emphasize this reality.

Claims and Lawsuits Arising from CRP Cases

About 22 percent of CRP cases resulted in a malpractice claim or lawsuit. Is this number low or high? Contextualizing it is difficult. On the one hand, fears that routine disclosure of adverse events could generate an avalanche of litigation (Studdert et al. 2007) clearly have not been borne out in institutions that have coupled disclosure with other CRP elements (Kraman and Hamm 1999; Boothman et al. 2009; Grenon et al. 2015)—including the New York

hospitals. On the other, having a fifth of CRP cases progress to a claim would not be a pleasing result for many insurers.

Plausibly, some of these claims might have been prevented had the New York hospitals followed through with compensation offers in cases that appeared to merit them. For example, in one case involving clear error, the hospital instead decided to maintain contact with the patient to see if she expressed interest in compensation. They called her twice, with no response. Months later, she sued.

Yet half the claims and lawsuits arose from incidents where the hospital, after investigation, concluded it had no liability and explained this to the patient. Often, patients appeared to leave the hospital content with this response. The subsequent claims are a disappointing outcome, but hardly a strike against CRPs—they may well have occurred even if the hospital had not given an explanation and expressed regret for the harm.

The Prevalence of Nonerror Events

The CRP primarily functioned as a communication program for harm events for which the providers were not culpable, rather than a compensation program for cases in which they were. Three-quarters of events were judged not to have involved a standard-of-care violation.

Possibly, risk managers misclassified some events as not involving a standard-of-care breach due to subconscious resistance to acknowledging error or excessive deference to surgeons' explanations for adverse outcomes. However, several circumstances suggest otherwise. Risk managers' professional responsibility is to protect the institution from costly litigation, and the risk managers in this project invested considerable time and effort in developing the CRP as a strategy for meeting that obligation. Risk managers strongly asserted that they did not accept clinicians' version of events without independent investigation, and the data show that they consulted an expert in 94.4 percent of investigations. Also noteworthy is that another project testing CRPs in six Massachusetts hospitals found a similar proportion of events involved substandard care (Mello et al. unpublished data).

Assuming that risk managers' standard-of-care judgments are reasonable, an important finding of our study is that although public discussion about CRPs focuses on their role in resolving errors, in practice, their work lies primarily in investigating and communicating with patients about harms not caused by negligence. This is a critical role, because patients'

misunderstanding about the cause of adverse outcomes can generate anger and litigation (Hickson et al. 1992; Hickson and Entman 2008).

Contributions of the CRP to Patient Safety Improvement

Two patient safety implications of our data are notable. First, CRPs can be quite helpful in supporting physicians in communicating about adverse events. In free-text comments, risk managers noted that especially successful disclosure conversations occurred where the surgeon had undergone disclosure training and/or had involved Patient Services to offer support services to the family.

Second, two human factors were frequently present in cases in which the standard of care was violated: intrateam communication and inattention. Half those cases were judged to involve a system failure in addition to (or in a few cases, instead of) a failure of an individual practitioner. These findings are consistent with those of a large study of closed malpractice claims including clinical areas beyond surgery (Studdert and Mello 2008). They provide an empirical basis for hospitals to be proactive in resolving harm events, because hospitals commonly share with practitioners both causal responsibility and potential liability for adverse outcomes.

These findings also highlight the importance of CRPs' role as patient safety improvement programs. By documenting investigation findings and ensuring that analysis of human factors is part of those reviews, CRPs can generate critical data for pattern analysis of harm events. By ensuring that CRP processes routinely consideration of interventions that could help prevent recurrence—and communication with Quality offices to ensure that action is taken—institutions can help ensure that their efforts have a multiplier effect beyond resolution of individual cases. For our project hospitals, for example, the need to bring further training and guidance to bear to improve intrateam communication was highlighted.

Experiences of Involved Providers

Clinicians were generally quite satisfied with how their cases had been handled by the CRP. Their lowest ratings related to how fairly the patient and family were treated. That finding merits further exploration, although eliciting patients' experiences in CRPs poses legal and ethical challenges. In several projects evaluating CRPs, hospitals' legal counsel have expressed concerns that such surveys could stir up anger and, perhaps, litigation.

Clinicians' low reported familiarity with the CRP suggests the hospitals did not build high-visibility CRPs. Rather, they operated their programs primarily as modifications to internal risk-management processes. This may not affect resolution outcomes, but greater visibility could help foster an atmosphere in which clinicians feel supported in communicating with patients about adverse events. It may also help dispel fears that CRPs offer "handouts" where physicians are not at fault for adverse outcomes.

CONCLUSIONS

Our findings indicate that even when hospitals are not able to discharge all CRP key elements consistently, they garner benefits in the areas of communication with patients/families, clinician support, and patient safety. Due to the frequent discordance between what was determined to be appropriate in terms of compensation offers and what was actually communicated to patients, measuring prospects for improving liability outcomes and generalizing from the New York hospitals' experience in that area are harder. The hospitals' CRP events did not result in a flood of malpractice claims and lawsuits, as some had feared, but deterrence of claims might have been even stronger had early offers been more consistently delivered where the standard of care was violated. Factors that contributed to reluctance to offer compensation more proactively in these hospitals have been discussed elsewhere and include aversion to the risk that a modest offer could trigger litigation pressing much larger demands (Mello et al. 2014a). Future adopters of CRPs are likely to reap the greatest rewards if they anticipate and address barriers to consistent application of the process reported by those who have come before (Boothman et al. 2009; Mello et al. 2014a, b, 2016).

The New York hospitals provided extraordinary transparency into the inner workings of their CRPs. The learnings should help other institutions considering adopting CRPs understand what to expect and how to maximize the benefits of this promising, but challenging, new model.

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SUPPORTING INFORMATION

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

Appendix SA1: Author Matrix.