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Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters

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ABSTRACT In communication-and-resolution programs (CRPs), health systems and liability insurers encourage the disclosure of unanticipated care outcomes to affected patients and proactively seek resolutions, including offering an apology, an explanation, and, where appropriate, reimbursement or compensation. Anecdotal reports from the University of Michigan Health System and other early adopters of CRPs suggest that these programs can substantially reduce liability costs and improve patient safety. But little is known about how these early programs achieved success. We studied six CRPs to identify the major challenges in and lessons learned from implementing these initiatives. The CRP participants we interviewed identified several factors that contributed to their programs' success, including the presence of a strong institutional champion, investing in building and marketing the program to skeptical clinicians, and making it clear that the results of such transformative change will take time. Many of the early CRP adopters we interviewed expressed support for broader experimentation with these programs even in settings that differ from their own, such as systems that do not own and control their liability insurer, and in states without strong tort reforms.

Policy makers and health care providers are keenly interested in whether communication-and-resolution programs (CRPs) can address dysfunctional aspects of the medical liability system. In CRPs, health systems and liability insurers encourage the disclosure of unanticipated care outcomes to affected patients and their families and proactively seek resolutions, which may include providing an apology; an explanation; and, where appropriate, an offer of reimbursement, compensation, or both.

Anecdotal reports from the University of Michigan Health System and other providers suggest that CRPs can substantially reduce liability costs and improve patient safety.[1–8] In 2010 the Agency for Healthcare Research and Quality funded several demonstration projects to test the communication-and-resolution approach. Results are beginning to trickle in, but institutions considering the use of CRPs still have scant information about how they work. To fill this gap, we studied six pioneering CRPs that follow one of two distinct models: early settlement and limited reimbursement.

Programs using the early-settlement model investigate whether the unanticipated outcome was caused by a lapse in the standard of care and do not exclude any cases from their CRP or limit payouts (Exhibit 1). Program administrators communicate with patients or families while a rapid investigation of the unanticipated

EXHIBIT 1

Communication-And-Resolution Program Models

	Early settlement	Limited reimbursement
Investigation into standard of care	Yes	No
Exclusion criteria	None	All programs: death; attorney involvement, notice of complaint, or attorney's request for records; written demand for payment; complaint to state medical board or regulatory agency Coverys: serious injury Coverys and WVMIC: dissatisfaction with aesthetic results of cosmetic surgery
Payout limit	None	$30,000 (excluding waived medical bills)
Compensation types offered	Waiver of medical bills, all economic losses, noneconomic losses	Out-of-pocket expenses, loss of time; waiver of medical bills is encouraged, but provider decides
Valuation method	As in tort litigation	Expenses reported by patient and provider
Release of claims required	Yes, for compensation beyond waiver of medical bills	No
Payments reported to NPDB and state licensing board	UMHS: no (payments are made on behalf of the institution only) SUMIT: yes, if hospital assigned responsibility primarily to a clinician instead of to a system failure UIMCC: yes, absent "good faith reason not to report"[a]	No
Physician participation	UMHS and SUMIT: presumptive unless the physician refuses to participate UIMCC: mandatory	Physicians opt to enroll

SOURCE Authors' analysis of data provided by program administrators. **NOTES** WVMIC is West Virginia Mutual Insurance Company. NPDB is National Practitioner Data Bank. UMHS is University of Michigan Health System. SUMIT is Stanford University Medical Indemnity and Trust Insurance Company. UIMCC is University of Illinois Medical Center at Chicago. [a]For example, the payment was made purely because the cost of defending the suit was higher than the cost of settling it, because the suit named an uninvolved provider, or because the suit involved only a system error and the provider's behavior was totally appropriate.

care outcome is conducted. The administrators explain the investigation's findings to the patient or his or her family, admit any errors, and apologize for the harm caused.

If the care that was provided is assessed as substandard, the program administrators offer the patients or family appropriate compensation, assessing the value of the case by considering what the damages likely would be in traditional litigation or what is required to meet the patient's expressed needs. The administrators also implement care improvements to address patient safety failings brought to light by the unanticipated care outcome. The patient must sign a release of claims in order to accept compensation, except for small payments to cover such expenses as hotel bills and waivers of professional fees. If the care is determined to have been reasonable, program administrators, sometimes with the involved physicians, explain to the patient or family the basis for their conclusions and seek understanding, but they commit to defending the provider if necessary.

Programs using the second model, limited reimbursement, have more limited scope, as their name implies (Exhibit 1). Cases are excluded from the CRP when the injuries are severe or the patient or family has taken steps toward litigation, or when other disqualifying factors are present. The programs encourage but do not directly facilitate disclosure conversations. Program administrators determine whether the unanticipated care outcome was caused by the medical care that was delivered or was the result of the patient's underlying disease, based on discussions with the providers involved. Administrators of these programs do not review the quality of care or talk with patients about it. However, providers are encouraged to tell patients what is known with reasonable certainty about what occurred.

Payouts are limited to reimbursement of out-of-pocket expenses and a modest daily payment (generally $100) for loss of time, and the total payout cannot exceed $30,000. Involved providers may opt to waive medical bills. Patients do not waive their right to sue by accepting reimbursement.

Because payments to patients or families by a limited-reimbursement CRP are not made in response to a patient's written claim and there is no subsequent release of claims, the payments are

not required to be reported to the National Practitioner Data Bank or state boards of licensing. (The National Practitioner Data Bank is a limited-access federal repository for adverse information about health care providers, such as malpractice awards.) In contrast, early-settlement programs take diverse approaches to reporting payments (Exhibit 1).

The two models have several similarities. Both seek to foster improved communication and proactively address patients' needs. Both offer clinicians just-in-time disclosure coaching and support. Both emphasize ongoing communication with patients or their families to share what has been learned, assess family needs, and preserve a strong patient-provider relationship. Both encourage clinicians to lead the initial disclosure conversation with patients or families, but both have program administrators conduct subsequent discussions about resolution.

Our aim was not to measure the programs' effects but to disseminate lessons learned about what the early adopters of CRPs regard—and have to some extent publicly documented[1–8]—as successful practices. In this article we identify both challenges that institutions might face in implementing CRPs and strategies that helped early CRP adopters overcome these challenges.

Study Data And Methods

This study was carried out by academic investigators (Thomas Gallagher, Michelle Mello, and Benjamin Dunlap) with assistance from leaders of the six CRPs discussed in this article.

CRP SITES The academic investigators selected six CRPs to study. Three of the programs—operated by the Stanford University Medical Indemnity and Trust Insurance Company, the University of Illinois Medical Center at Chicago, and the University of Michigan Health System—are early-settlement programs. The other three—operated by the COPIC Insurance Company, the West Virginia Mutual Insurance Company, and Coverys (formerly known as ProMutual Group)—are limited-reimbursement programs (Exhibits 1 and 2).

These programs were selected because they are some of the longest-running CRPs in the United States. Each site formalized its approach into an identifiable program that was branded and marketed to clinicians. And all of the programs include a systematic early-compensation component. Other institutions have been early adopters primarily of the communication (disclosure and apology) elements of the communication-and-resolution approach but have had less fully developed early-compensation or resolution components.

Veterans Affairs hospitals were the earliest adopters of the communication-and-resolution approach.[9] However, we excluded them out of concern that their experiences might not be generalizable. We were not aware that any other institutions met our selection criteria at the time of the study.

INTERVIEW METHODS The investigators worked with the leaders of each CRP to identify seven to nine people, in addition to the program leader, who were highly knowledgeable about the program and who agreed to be interviewed. At each site, the interviewees included program leaders, risk managers, clinicians who had experience with the program, and attorneys or others

EXHIBIT 2

Characteristics Of Communication-And-Resolution Programs

	Early-settlement model: self-insured hospital systems			Limited-reimbursement model: noncaptive medical professional liability insurers		
	UMHS	SUMIT	UIMCC	COPIC	WVMIC	Coverys
Providers						
Hospitals	3	2	1	0	0	20
Physicians	4,091	2,425	800	5,885	1,350	1,850
Others	8,122	0	40	0	0	70
States covered	MI	CA	IL	CO, NE	KY, OH, VA, WV	CT, DE, ME, MD, MA, NH, NC, SC, VT, VA
Launch date	3/02	9/07	4/06	10/00	11/06	10/08
Cases opened	696	96	312	4,354	80	152
Cases closed with payment	309	9	171	2,678	43	74
Cases closed without payment	331	72	141	1,311	—[a]	56

SOURCE Authors' analysis of data provided by program administrators, December 2012–July 2013. **NOTES** "Noncaptive" refers to a professional liability insurance company that is not owned and controlled by health care facilities in a self-insurance arrangement. UMHS is University of Michigan Health System. SUMIT is Stanford University Medical Indemnity and Trust Insurance Company. UIMCC is University of Illinois Medical Center at Chicago. COPIC is COPIC Insurance Company. WVMIC is West Virginia Mutual Insurance Company. [a]Cases are never considered closed in this program.

responsible for handling claims. Interviews were conducted face-to-face in 2010, except for a few cases where scheduling constraints necessitated a telephone interview instead.

Interviews were semistructured, lasted forty-five to sixty minutes each, and were conducted by two of the investigators. Questions were drawn from a thirty-five-item interview guide. Question domains included the interviewee's background, program implementation, program design and operation, and metrics for assessing program effectiveness.

Each person was interviewed alone, except in one case, where two people were interviewed together. Interviews were recorded and transcribed. The Institutional Review Boards of the Harvard School of Public Health and the University of Washington approved the study.

DATA ANALYSIS We used thematic content analysis to identify and excerpt dominant themes in the transcripts. Two of the investigators each developed an initial coding scheme by independently coding a sample of transcripts. They then compared themes, discussed and resolved the differences in their initial coding, and finalized the coding scheme. Each transcript was then coded by one investigator using the NVivo 9 software package.

Finally, the investigators analyzed text that had been coded within particular themes to identify overall findings. CRP leaders verified the accuracy of a draft of this article and provided descriptive data about their programs.

LIMITATIONS We did not independently ascertain the programs' success in improving key outcomes. Our sample disproportionately comprised program administrators, who—although highly knowledgeable—might have subconsciously amplified their program's success.

The physicians we interviewed were identified by program administrators and might have viewed the programs more favorably than other physicians did. The perceptions of the interviewed physicians were not uniformly positive. However, we might have obtained different overall responses had we interviewed more people.

Recall bias might have affected interviewees' reports. Finally, the programs we studied might not be representative of all CRPs.

Study Results

RESPONDENT AND SITE CHARACTERISTICS We interviewed forty-five people. Nearly half of them were program leaders or staff members (Exhibit 3).

The three early-settlement programs had all developed in self-insured hospital systems. In contrast, the limited-reimbursement programs had been begun by noncaptive medical professional liability insurers—that is, carriers that were not controlled by the facilities they insured. The programs varied widely with respect to the numbers of physicians they covered and cases they had handled (Exhibit 2).

KEY DESIGN DECISIONS The decisions made by participants at each site as to which program model to follow were driven by three major questions.

First, is it desirable to investigate the standard of care? Participants at the three early-settlement sites felt that offering compensation only in

EXHIBIT 3

Interviewees' Programs And Roles

	Interviewees	
	Number	Percent
PROGRAM		
COPIC Insurance Company	9	20
Coverys	7	16
Stanford University Medical Indemnity and Trust Insurance Company	7	16
University of Illinois Medical Center at Chicago	8	18
University of Michigan Health System	8	18
West Virginia Mutual Insurance Company	6	13
INTERVIEWEES' ROLE IN INSTITUTION		
CRP leader	12	27
CRP staff member[a]	10	22
Legal counsel	6	13
Other leader	7	16
Physician	10	22

SOURCE Authors' analysis. **NOTES** Forty-five key informants were interviewed. Percentages may not sum to 100 because of rounding. CRP is communication-and-resolution program. [a]Staff members included risk managers and claims handlers.

cases where the care had been unreasonable was essential to winning buy-in from physicians. These participants also decided that investigating the quality of care was important because doing so would identify opportunities to improve safety.

In contrast, participants in the limited-reimbursement programs felt that this model's no-fault approach would increase participation by reassuring physicians that the program would not lead to adverse consequences. In addition, participants felt that the limited-reimbursement approach overcame some practical problems, such as difficulty in accessing medical records quickly.

Second, should eligibility criteria or other limitations be imposed? Early-settlement programs, which lack such restrictions, can address the serious injuries that most concern hospitals' risk managers and safety experts. Yet administrators at limited-reimbursement programs noted that regulatory considerations favored the adoption of certain exclusion criteria. For instance, excluding cases involving a written demand for payment freed administrators of limited-reimbursement programs from the obligation to report payments to the National Practitioner Data Bank.

Third, should patients be permitted to have attorneys represent them in the resolution of the unanticipated outcome? The three early-settlement programs allowed, and in some cases welcomed, attorneys' involvement. Leaders at these programs felt that attorneys were often helpful in managing patients' expectations about the value of their case. Attorneys' participation frequently facilitated resolution, especially when the attorney was experienced and had developed over time a relationship of trust with program administrators.

In contrast, none of the limited-reimbursement programs that we studied allowed patients to have legal representation. Administrators at these CRPs believed that attorneys' involvement tended to make resolution discussions adversarial, which hindered administrators' attempts to develop a positive relationship with patients. Some of the administrators noted that patients could opt out of the CRP at any time and pursue a traditional claim, yet this rarely occurred.

MOTIVATIONS FOR ADOPTING A CRP Participants in all six CRPs commented that they saw their programs as an opportunity to address problems in the liability environment. Participants in the early-settlement programs indicated that program founders were also motivated by dissatisfaction with their institution's previous approach to unanticipated care outcomes.

For example, prior to implementing its early-settlement program, one hospital had experienced the death of a young patient caused by what was described as a clear error. Hospital representatives responded by adopting their normal "deny and defend" approach of sharing little information about what happened with the family and not admitting that the death had been caused by an error. Physicians at that hospital indicated that they were troubled by the lack of a process to approach the deceased patient's family, which might have given them an opportunity to acknowledge to the family that the death had been preventable and to apologize. Hospital administrators lamented the case, saying that the hospital had paid an "enormous [amount of] dollars to defend what a lot of people thought was indefensible."

Risk managers at another hospital with an early-settlement program said that they disliked having to litigate instead of explaining to patients early in the process why their claims lacked merit. An interviewee at the third early-settlement program reported that the medical and financial staff had been "quite dispirited" because the institution had previously "settled virtually everything" to avoid the risks of going to trial and had never asked, "What should we learn from this?"

We asked participants at each study site whether the decision to adopt a CRP had been driven more by economic considerations or by a sense that it was the right thing to do for patients and providers. Interviewees at all sites reported that both of these factors had been strong drivers. Participants at the University of Michigan Health System observed that the business case had motivated institutional executives and legal counsel, while the ethical considerations had motivated clinical leaders.

OBSTACLES ENCOUNTERED IN LAUNCHING PROGRAMS Participants reported encountering two major obstacles in the early days of their programs, both related to winning physicians over. First, participants at five of the six sites reported practical challenges in educating their physicians about the program—especially at sites where physicians were dispersed across many practices, states, and insurance agents.

Second, program founders initially struggled to overcome physicians' skepticism. Many physicians were uncomfortable with making disclosures to patients, probably because of a lack of training in disclosing errors and a cultural disinclination to admit error. Other clinicians worried that disclosures and settlement offers might increase their liability risk. Program leaders had little evidence they could use to assure clinicians that the fear of increased liability exposure was unfounded. Thus, the leaders worked to shift

physicians' focus from legal risk to "doing the right thing."

Insurers enjoyed strong, trusting relationships with physicians at some of the CRP sites, while insurers at other sites had to convince physicians that the insurers would be "working with them, not pointing fingers" or trying to identify the "bad apples." Administrators of the limited-reimbursement CRPs stressed to clinicians that participating in their program would not lead to increased premiums. Similarly, administrators of the early-settlement CRPs explained to clinicians that premiums would be unaffected unless several incidents raised suspicion of provider incompetence.

Another concern of physicians was that participation in a CRP could trigger reports about them to the National Practitioner Data Bank and state regulators, which might have adverse reputational, credentialing, or disciplinary consequences. Administrators of the limited-reimbursement CRPs explained to physicians that payments made via the program were not required to be reported to federal and state authorities, which was "a clear selling point for bringing physicians into the fold."

Administrators of the early-settlement programs had a harder time overcoming physicians' concerns about reports to federal and state authorities. Administrators at two of these programs developed a compromise: They would report to authorities payments made to patients or families only in cases where it was determined that the physician, rather than a "system failure," had been primarily responsible for the error (Exhibit 1).

Factors Facilitating Programs' Success

THE CRITICAL ROLE OF INSTITUTIONAL CHAMPIONS Participants in all of the CRPs attributed much of their program's success to talented and dedicated institutional champions, who ranged from senior administrators to on-the-ground staff members. "You have to have somebody who is really willing to, in a sense, attach themselves to [the program] and sell it," one interviewee commented.

CRPs' greatest champions were inspirational program founders, who were able to elicit support from key institutional leaders. In fact, the founder's role was deemed so important that many interviewees wondered whether their program would have survived had the founder left the institution in the program's early days.

Senior clinical leaders and respected physicians also served as program champions at some sites. Interviewees considered them to have been essential to securing buy-in from clinicians.

EXTENSIVE OUTREACH TO CLINICAL STAFF Participants at all sites mentioned that effectively marketing the CRP to clinicians was crucial to its success. Program administrators sought to inform clinicians about all aspects of the CRP and to allay their concerns. Clinicians were told whom to contact with questions and were assured the insurer would "stand behind" them.

Clinicians were also given information about program results, including patient safety interventions and success stories illustrating the CRP's benefits to physicians and patients. One program administrator commented that "the doctors come in all grumpy and everything; they're not interested," and they attended an educational session about the CRP and the importance of effective disclosure only to get a 5 percent reduction in their insurance premium. The administrator continued: "And about a third of the way through the program the dynamic changes. ...Then you can't get them out of the room."

THE CULTURE OF TRANSPARENCY Interviewees recognized that they cannot promote the effective resolution of unanticipated care outcomes that they do not know about. Thus, they indicated that a strong culture of early reporting was vital to their CRP's success. Some participants reported that their hospitals had a strong culture of transparency when they established a CRP. Other participants indicated that they had to work to build a culture of early reporting of unanticipated care outcomes.

One incentive for early reporting of these outcomes arises from claims-made insurance policies, which are now the dominant form of malpractice insurance. To trigger coverage, providers with such policies must notify the insurer of any unanticipated care outcome or any claim filed by a patient or his or her family during the policy period. This incentive, along with extensive outreach to assure physicians that reporting unanticipated care outcomes would not result in adverse consequences, contributed to frequent early reporting at the CRP operated by COPIC Insurance, according to administrators there.

Another incentive for early reporting, adopted by the University of Illinois Medical Center at Chicago, is an insurance surcharge. If the hospital first became aware of an unanticipated care outcome through a notice of claim from the patient or family, a premium increase of $50,000 per incident was levied against the hospital department whose staff failed to report the event.

DEVOTING RESOURCES TO THE PROGRAM Leaders of the CRPs in our study emphasized that the programs require more work than traditional

claims management processes. This is because using a CRP increases both the number of unanticipated care outcomes that are investigated and the time pressure of the investigations. What's more, those programs involve additional time communicating with families.

Furthermore, interviewees noted that implementing a successful program required devoting considerable time to developing program policies and procedures and to marketing the program. Starting a CRP might require more staff than following traditional claims management processes.

ADVANTAGES ENJOYED BY CAPTIVE INSURERS Three of the study sites—the University of Michigan Health System, the Stanford University Medical Indemnity and Trust Insurance Company, and the University of Illinois Medical Center at Chicago—involved captive insurers. A captive insurer is a wholly owned insurance company whose sole purpose is to provide liability coverage for the organization that created it; it is a common way for organizations to insure themselves. Interviewees at these sites attributed some of their program's success to having a relatively high degree of control over their hospital's medical staff, since the same institution both employed and provided medical malpractice liability insurance to these physicians.

They also noted an important alignment of incentives: When a captive insurer saves money through a CRP, departments pay less to the insurer. Department chairs "love that," so they are eager to promote the CRP to their staff members and encourage the reporting and disclosure of unanticipated outcomes.

THE ROLE OF THE LIABILITY ENVIRONMENT When we asked whether the current liability environment had proved helpful or challenging to the successful operation of the CRPs, we received mixed responses. Some interviewees felt that physicians were interested in a new approach but also feared that disclosing errors could elevate their risk of litigation. Other interviewees reported that the liability environment did not affect the program's success. In the case of limited-reimbursement programs, interviewees believed that the environment encouraged physicians to participate.

We also asked whether participants viewed tort reforms, such as damages caps and laws protecting statements of apology from being admitted into evidence in a lawsuit, as important. None of the interviewees thought that tort reforms were essential for the success of a CRP.

Participants in two of the limited-reimbursement programs felt that apology laws were helpful and encouraged physicians to participate in the programs. Interviewees from the other four sites said that they were unconcerned that information from disclosures might buttress the case of a plaintiff in a lawsuit because they intended to settle any case in which they admitted error.

Interviewees at two programs indicated that their state's cap on noneconomic damages probably helped their CRP succeed, especially in terms of assessing the value of serious injuries. Two other interviewees commented that "cooling-off period" laws—which require malpractice plaintiffs to give defendants advance notice of their intention to sue—facilitate CRPs by giving the insurer time to collaborate with the patient and family on developing an acceptable resolution.

Ongoing Challenges

CONDUCTING RAPID AND THOROUGH INVESTIGATIONS Striking the right balance between speed and thoroughness in reviewing unexpected care outcomes is challenging, especially for programs that investigate the reasonableness of care. Meeting an expedited timeline sometimes diverts risk managers from other work and can be difficult to achieve in complex cases.

Program staff members work hard to avoid drawing inaccurate conclusions and acknowledged that sometimes they had to be flexible about the timeline. Particularly challenging were cases where the long-term effects of the injury were unclear.

ENSURING TIMELY INCIDENT REPORTING Participants at most sites considered their efforts to increase the completeness and timeliness of event reporting by physicians to be a work in progress. One persistent barrier is physicians' fear of being blamed for adverse events that were primarily system failures. A related fear is that the CRP might make settlement decisions according to what is best for the institution, not the physician.

WINNING OVER PHYSICIANS Program administrators reported that most physicians were supportive of the communication-and-resolution approach, especially once they had some personal experience with the CRP. Nonetheless, administrators perceived a need for ongoing outreach to physicians.

One administrator of a limited-reimbursement program noted that despite dogged attempts to reach out to policyholders in multiple states, the physicians' level of response had been disappointing.

COORDINATING WITH OTHER INSURERS Unanticipated outcomes of care can involve multiple providers and institutions that have different malpractice insurers. This complexity poses enormous challenges for CRPs. Even partici-

It was a challenge to keep families from having unrealistically high expectations for compensation.

pants in the early-settlement programs, which are based at hospitals that employ and insure their physicians, reported challenges working with other facilities or with providers with different insurance.

In cases involving multiple insurers, each insurer may seek to shift financial responsibility to others. Insurers also may have different philosophies about settlement. For example, some insurers might adopt a highly proactive approach and reach out to the patient after the error to propose compensation. In contrast, other insurers might prefer to wait for the patient to request compensation before making a financial offer. Some insurers might settle cases that they believed lacked merit but that they nonetheless feared might result in a large jury verdict, while other insurers might steadfastly refuse to settle to deter attorneys from bringing nonmeritorious cases.

Finally, physicians who are not employed or insured by the institution operating the CRP might be unwilling to participate in disclosure or to consent to a settlement. If some of the parties "don't want to play ball with you," one administrator explained, it's hard for the communication-and-resolution process to work. In cases where multiple parties shared responsibility for the error, institutions were reluctant to be the only ones acknowledging their role in the error to the patient.

MANAGING PATIENTS' EXPECTATIONS AND PERCEPTIONS Participants in all six programs reported that it was a challenge to keep families from having unrealistically high expectations for compensation. Interviewees at early-settlement programs sometimes spent months talking with patients and families who felt entitled to compensation, although the institution had determined that there had been no standard-of-care violation. Interviewees at limited-reimbursement programs worried that patients would view a reimbursement offer as an admission of fault.

Early and frequent contact with patients and families, including repeated explanations of the nature and limitations of the CRPs, was needed to avert such misconceptions. Participants in limited-reimbursement programs also sought to avoid creating the impression that their no-fault program would pay in any case in which care did not produce the hoped-for results.

HOW PROACTIVE IS 'PROACTIVE'? All early-settlement programs strive to offer compensation proactively, but they take different approaches. The claims manager at one of these programs in our study reportedly tells families that "we've reviewed the case, we think there was some human error involved, [and] we do want to resolve it" and then states what the institution believes reasonable compensation would be.

At another of the sites, administrators usually wait for the patient to raise the issue of compensation. At that point, cases involving clear error are referred to a "rapid settlement" team, whose members make a compensation offer. If it is not clear that an error occurred, team members may wait for the patient to contact them.

At the third site, administrators try to elicit what remedies the patient is seeking, asking questions such as, "What are you looking for, and what would make this better for you?" and, "How could we resolve this for you?"

All three programs routinely hold medical bills immediately after an adverse event and waive them permanently when the care is deemed to have been inappropriate. However, only one of the programs indicated that being proactive required making a compensation offer before the patient signaled an interest in receiving one.

IMPROVING PATIENT SAFETY Administrators at all six programs believed that rates of adverse events had decreased because the programs fostered a culture of safety and of incident reporting, which in turn facilitated more event analyses and the identification of interventions to improve safety. Yet interviewees at all of the programs also recognized that there was still much room for improvement in making full use of lessons learned for improving patient safety.

Interviewees at limited-reimbursement programs found it especially challenging to ensure that lessons learned were translated into new ways to improve care. This difficulty arose because the clinicians covered by these programs were dispersed among many practice organizations and hospitals.

Lessons For Other Organizations

Our study of the experiences of six pioneering CRPs suggests several broad lessons for other organizations that are considering whether and how to implement such programs.

PROGRAM BUILDING IS AN INVESTMENT Pro-

gram leaders emphasized that there is a difference between applying elements of the communication-and-resolution approach on an ad hoc basis and developing a full program. The latter involves obtaining institutional commitment to disclosure, apology, and early compensation even when these are not clearly in the insurer's interest; developing standard operating procedures and training staff to apply them consistently; branding and marketing the program; and providing adequate staff resources to conduct more incident reviews with greater speed.

Thus, building a CRP requires time and resources. Each program in our study has at least one attorney or other administrator who has devoted all or a significant proportion of his or her time to the program.

Investing energy and political capital to secure buy-in from institutional leaders and clinicians is especially critical,[2] and making those investments was the most common piece of advice that our interviewees offered. Institutions that adopt a CRP should expect to conduct outreach on the program's behalf for at least one year before its launch and for several years afterward.

Interviewees offered some specific suggestions for how to effectively market a CRP to clinical staff. First, emphasize the following three selling points of the program: the business case (the program's potential for reducing liability costs), "doing the right thing" for patients, and improving quality and safety.

Second, clearly communicate the message that the institution unequivocally supports providers—but this sometimes means telling them candidly that settlement is appropriate. Defending bad care and dragging litigation out only to pay just before a case goes to trial do not serve providers' interests.

Third, consider offering physicians a financial incentive, such as an insurance premium reduction, to encourage them to participate. Fourth, as experience with the program accumulates, share success stories with physicians, enlisting involved clinicians to talk with their peers.

Fifth, make the outreach as personal as possible. Face-to-face presentations serve to build trust as well as convey information.

Sixth, share information about program outcomes, because clinicians respond favorably to data. Finally, provide disclosure training and coaching, since investments in ensuring that disclosure conversations are done right can pay dividends.

A STRONG CHAMPION IS ESSENTIAL Interviewees repeatedly commented that their program would never have succeeded without the efforts of one or more committed champions. Successful champions were passionate about the communication-and-resolution approach, dogged in their advocacy of it, shrewd about organizational politics, charismatic, and willing to take risks.

If a champion was not a clinical leader, he or she typically recruited a close ally who was. Champions also surrounded themselves with a small cadre of talented, like-minded program staff members.

KNOW YOUR ORGANIZATION Program founders made strategic choices about the design of their CRP based on their organization's structure, culture, and needs. For example, limited-reimbursement programs might be an easier sell than early-settlement programs in highly risk-averse organizations. In contrast, early-settlement programs might be more appealing to organizations that want reduce high liability costs and improve their safety culture. Obtaining participation in these programs from clinicians will be easier in situations where they have a long-standing relationship of trust with the insurer.

Although organizational structure is important, most interviewees stressed that both types of programs could be successfully operated by different kinds of organizations. Captive insurers enjoy advantages in implementing early-settlement programs. Nonetheless, interviewees in organizations that self-insured for malpractice liability through a captive insurer dismissed suggestions that this model would not work in other settings. They argued that the organization's form mattered less than whether it was willing to devote resources to the program and could identify a champion.

DO NOT BE DETERRED BY THE LEGAL AND REGULATORY ENVIRONMENT Health care leaders sometimes voice reluctance to adopt CRPs without strong tort reforms such as damages caps and apology laws. Our interviewees felt that such laws were helpful, but not essential, and encouraged experimentation with CRPs even in high-stakes liability environments. Some participants felt that an adverse liability environment helped generate enthusiasm for a new approach. Careful program design and physician education can help ensure maximum benefit from the protective laws that do exist.

Our interviewees uniformly agreed that requirements to report payments to the National Practitioner Data Bank, state boards, and other regulators served as a barrier to early settlement and were a major reason why some organizations prefer a limited-reimbursement program. All program leaders advocated working with the state insurance department and boards of licensing on program design, to ensure that reporting requirements are triggered as seldom as possible and that regulators understand that the insurer is not trying to protect problem physicians.

Sites used mechanisms outside the CRP to address concerns about providers' competence or behavior. Early-settlement programs referred the issue of provider competence or disruptive behavior to robust processes of peer review in hospital departments.

The University of Illinois Medical Center at Chicago also used data on patient complaints to identify physicians who needed to improve their communication with other providers or with patients. The hospital operated a program in which it trained peers to work with these physicians on strategies for improvement.

Limited-reimbursement programs relied on mechanisms such as alerting the insurer's risk management department about providers whose experiences with the CRP suggested that they were struggling to provide high-quality care or interact effectively with patients or peers, so that continuing medical education programs could be offered to these problem physicians.

Conclusion

For most health care organizations, implementing communication-and-resolution strategies involves transformative culture change. Our interviewees advised those who create a CRP to "be patient" and anticipate gradual culture shift and returns on investment over several years—advice that is borne out by existing reports of program outcomes.[1]

Making disclosure and early reporting of unanticipated care outcomes routine might happen quickly in some organizations but more slowly in others. The effect of a CRP on indemnity costs might not be fully visible for several years, since patients typically have two or three years after discovering an injury before they need to file a lawsuit.

This time horizon is one reason why knowing what challenges early CRP adopters faced and how they overcame those challenges is so valuable. The Agency for Healthcare Research and Quality's CRP demonstration projects are yielding important insights about implementing the communication-and-resolution approach in a range of institutional settings. However, understanding the full effects of a CRP requires longer observation than was possible in the time period for which these demonstration projects received funding. Insights from early adopters of the programs should serve to inspire and guide other organizations in pursuing CRPs while the evidence base continues to grow. ■

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NOTES

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