What's New in disclosure?
The AHRQ CANDOR Process and Toolkit

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Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

On September 9, 2009, President Obama directed the Secretary of the U.S. Department of Health and Human Services (HHS), who assigned AHRQ to establish an initiative that would help States and health systems test models that meet the following goals:

- Put patient safety first by reducing preventable injuries.
- Foster better communication between doctors and patients.
- Ensure fair and timely compensation for medical injuries while reducing malpractice litigation.
- Reduce liability premiums.

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In June 2010, AHRQ announced $23.2 million in funding for

- seven 3-year demonstration grants ($19.7 million total),
- thirteen 1-year planning grants ($3.5 million total), and
- a contract to evaluate the overall initiative and its projects.

MAIN AREAS COVERED BY THE 7 DEMONSTRATION PROJECTS

1. *Improving patient safety.* These projects sought to improve patient safety by measuring safety problems, characterizing adverse events, and conducting clinical safety interventions.

2. *Improving communication.* These projects addressed improved communication by assessing attitudes toward error and harm disclosure and implementing communication interventions in clinical environments.

3. *Exploring resolution methods.* These projects focused on medical liability interventions – variations of a disclosure, apology, and offer (DA&O) model as well as a safe harbor model.

RESULTS SUMMARY

- Of the 7 demonstration projects, only one **(University of Illinois Medical Center at Chicago (UIC))** reported strong statistical data. The other 6 were beset by difficulties such as absence of statistical data (descriptive only), lack of conclusions, uneven adherence to the research plan, poor buy-in of participants, insufficient number of cases, etc.

Not all plans worked out

- Title: A Plan To Use … Patient Complaints To Promote Safety/Reduce Claims - Award: $294,137
- "Even though only 2 of the 12 composites of patient safety culture measured …were found to be significantly related to patient complaints, this establishes new ground for future studies within the patient safety movement…."
- "Future studies will be necessary to study this possible relationship…"

One Was Impressively Successful

- Title: Removing Barriers to Disclosure-and-Offer Models - Award: $278,212
- Goals: identify barriers to implementation of disclosure, apology & offer (DA&O) programs in Massachusetts; develop strategies for overcoming these barriers; and create a roadmap or implementation guide for use by other organizations.
- “Importantly, this planning effort resulted in a historic and unprecedented partnership among physicians and attorneys from the Massachusetts Medical Society, Bar Association, and Academy of Trial Lawyers.”

One Was Impressively Successful

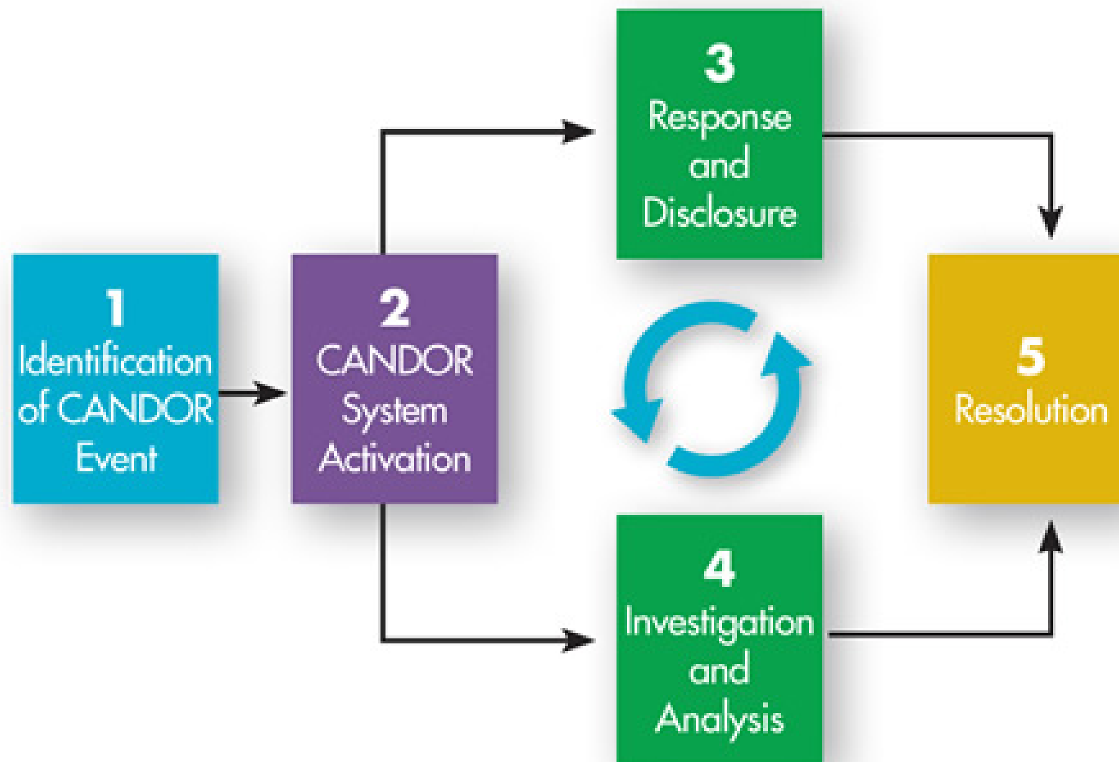
- The Mass. Plan: Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI), comprises representation of a variety of stakeholder groups. Since forming, MACRMI renamed the approach Communication, Apology, and Resolution (CARe); developed clear policies, procedures, algorithms, and guides for facilities implementing CARe; helped in developing projects piloting CARe in six hospitals in the State; and created a resource Web site (http://www.macrmi.info).

CANDOR Toolkit

- Implementation Guide for the CANDOR Process
- Module 1: An Overview of the CANDOR Process
- Module 2: Obtaining Organizational Buy-in and Support
- Module 3: Preparing for Implementation: Gap Analysis
- Module 4: Event Reporting, Event Investigation and
- Analysis Module 5: Response and Disclosure
- Module 6: Care for the Caregiver
- Module 7: Resolution
- Module 8: Organizational Learning and Sustainability

"We realize mistakes happen, and we can forgive that; but you harm us again by not being honest and transparent with us...we should be healing and learning together how to prevent this from happening to someone else."

Carole Hemmelgarn, Patient Advocate


1
Identification of CANDOR Event
2
CANDOR System Activation
3
Response and Disclosure
4
Investigation and Analysis
5
Resolution

Candor Process

- Very similar to disclosure and offer programs carried out by the VA, Univ. of Michigan, Univ. of Illinois, Stanford, Massachusetts (CARe) and others.
- Includes background material, instructional tools and techniques on starting such a program including getting buy-in and training staff.
- As there is so much material published on this subject, the Candor Toolkit is a convenient starting point.
- It’s all free.

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Clinicians & Providers

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Quality & Patient Safety

- AHRQ's Healthcare-Associated Infection Program
- AHRQuality Indicators™
- Comprehensive Unit-based Safety Program (CUSP)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Improving Diagnostic Safety
- Partnership for Patients
- Patient & Family Engagement
- Patient Safety Measure Tools & Resources
  - Tools and Resources

Communication and Optimal Resolution (CANDOR)

Communication **and** Optimal Resolution (CANDOR) is a process that health care institutions and practitioners can use to respond in a timely, thorough, and just way when unexpected events cause patient harm. This AHRQ toolkit, based on the CANDOR process, is intended to assist hospitals in implementing communication and optimal resolution programs.

A traditional approach when unexpected harm occurs often follows a "deny-and-defend" strategy, providing limited information to patients and families, and avoiding admission of fault. In short, the CANDOR process is a more patient-centered approach that emphasized early disclosure of adverse events and a more proactive method to achieving an amicable and fair resolution for the patient/family and involved health care providers.

Getting Started

- Implementation Guide for the CANDOR Process (PDF File, 504 KB)

Modules

Module 1: An Overview of the CANDOR Process

- Overview of the CANDOR Process Facilitator Notes (Powerpoint File, 1 MB)
- Tool: Grand Rounds Facilitator Notes (Powerpoint File, 7.5 MB; PDF File, 4.2 MB)
- Video: Introduction to Communication and Optimal Resolution (CANDOR)
- Video: Grand Rounds.

A process such as CANDOR may be straight forward or complicated depending on the complexity of the environment.

- How hard was it in the VA?

A Recent Example of How a Medical Mishap Should be Handled…

- **HONOLULU --** The widow and children of a man who went to a rural Hawaii health center with a sore throat in 2013 and ended up dead will receive a $4.2 million settlement from the federal government, the widow's lawyer said Wednesday.
- Antonio Marrero, 32, went to the emergency room of Waianae Coast Comprehensive Health Center, where a doctor determined he had an abscess in his tonsils and arranged for him to see an ear, nose and throat specialist, lawyer Richard Fried said.
- Then the doctor decided to further evaluate him under sedation, but Marrero lost consciousness and died, Fried said. …

AHRQ WEB ADDRESS

- http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html