In general terms, “candor” can be defined as “the quality of being open and honest in expression.” Within health care, this definition carries over when referencing CANDOR, the acronym for Communication and Optimal Resolution. CANDOR is a patient-centered process that supports early disclosure of adverse outcomes along with proactive steps to facilitate an amicable and fair resolution for the patients and providers involved.

The focus on CANDOR is due in part to efforts by the Agency for Healthcare Research and Quality (AHRQ). AHRQ launched a $23-million grant initiative in 2009 that used a CANDOR toolkit in 14 hospitals across three U.S. health systems. The toolkit promoted a shift from a “deny and defend” mentality to an environment that encourages open, honest conversations with patients after adverse outcomes occur. The process also is designed to investigate and learn from what happened, to address the providers’ needs alongside patients’ needs and to disseminate any lessons learned in order to improve future outcomes.

In the wake of the AHRQ initiative, an enhanced CANDOR toolkit was developed, with training modules to help implement this approach in other health care settings. The toolkit is available at https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html.

**Key elements of CANDOR**
The underlying components of CANDOR are based on the insight derived from the AHRQ initiative, coupled with expert evaluation on results that have demonstrated a positive impact. They include:

- **Reinforce early reporting and identification of events that CANDOR can address.** Perhaps the most underestimated element in terms of importance is the value of early identification of an adverse medical outcome. Creating an effective reporting culture around this requires a shift from blaming the individual physician to focusing on identifying system processes and related factors that may have contributed to the adverse outcome. Supporting a system that encourages rapid response also allows those involved to gather valuable information while the incident is fresh in everyone’s minds.

- **Assess and improve communication skills.** Breakdowns in the communication process, whether with patients/family or other members of the medical team, are often at the root of medical liability claims. Communication is not an equally shared skill; there are good communicators and there are good systems to enhance the coaching of communication. CANDOR seeks to develop the skills required in these situations, including empathy, sincerity, active listening, patience, tact and emotional intelligence. Finally, the initial communication should not be delayed, but be appropriate to what is reasonably certain to have occurred when it is known. Full disclosure is a process that continues as more information becomes available from an investigation into the adverse outcome.

- **Embrace efforts to care for the caregiver.** Harm to patients arising from medical care has a direct effect on the caregivers as well as the patients. Feelings ranging from blame and shame to worry about one’s effectiveness and an overwhelming sense of guilt can all become evident following harm to a patient in which professional acts, omis-

(continued on page 24)
CANDOR – Communication and Optimal Resolution

The CANDOR process is designed to help health care organizations and practitioners respond to unexpected patient harm events in a timely, thorough and just manner.

The CANDOR process helps hospitals improve their immediate response to harm and realize short- and long-term improvements in the monitoring and reporting of events by promoting candid, empathic communication and timely resolution for patients, caregivers and the organization.

A CANDOR event is an event that involves unexpected patient harm. The unexpected harm can be physical, emotional or financial.

— from the CANDOR Toolkit of the Agency for Healthcare Research and Quality

CentraCare is first Minnesota organization to adopt CANDOR process

Chelsie Bakken, RN, MBA, patient safety manager at CentraCare Health in St. Cloud, is a key player in introducing the CANDOR process to her organization—and she’s definitely a cheerleader for it.

“The moment I understood what it was all about, I couldn’t think of any better process we could put in place to make us the safest organization and also achieve our mission and vision,” she says. “It’s been an absolutely wonderful journey. Honestly, from a patient safety perspective, it’s an ideal model!”

CentraCare began looking at programs to improve safety and communication about 18 months ago, Bakken says. Several CentraCare executives had learned about the CANDOR process at conferences and it seemed to provide what CentraCare would want. “When we looked into CANDOR, we saw it as a full safety program,” says Bakken. “It has a component for discovery and learning around events, support for caregivers and a patient and family component with disclosure and resolution.”

It wasn’t as if CentraCare was starting from scratch; “We have a strong process here,” Bakken says. “CANDOR gives us an opportunity to strengthen connections among teams and with patients and their families. Not improve, but strengthen.”

Although the CANDOR process became state law in Iowa in 2015 as medical liability reform, CentraCare is the first Minnesota health care entity to adopt the process, Bakken says. CentraCare will implement CANDOR in July, a little over one year after it first began analysis and training.

In May 2018, the MedStar Institute for Quality & Safety (MIQS), began the first step of CANDOR, which included an information session for CentraCare leaders, information gathering and then interviews with board members, leaders, frontline staff and others. The information and interviews were used to develop a “gap analysis” to identify where more effort might be needed to introduce and implement CANDOR.

“After the gap analysis, you outline your plan, look at policies, procedures and processes and what you might need to change,” Bakken says. The implementation leaders then began to promote CANDOR, getting staff involved and engaged.

MedStar has helped lead formal training in a multi-step process as outlined by the CANDOR Toolkit. At the end of June, the consultants will work with CentraCare implementation leaders to share what has developed during the training sessions.

Overwhelmingly, Bakken says, staff who have participated in training sessions so far “have expressed gratitude and excitement.” The training has included everyone from nutrition services staff to physicians. “It’s a very all-inclusive approach.”

CentraCare has taken each of the components of CANDOR and assigned measures of success, so that after implementation the organization can look at whether and how the process has made a difference in everything from claims and settlements (“not historically a big risk for our organization,” Bakken says) to patient experience.

CANDOR includes a “care for the caregiver” program—this is what drew CentraCare to the program initially. Tim McDonald, MD, JD, the director of the Center for Open and Honest Communication at the MIQS and the creator of CANDOR, says, “By caring for our caregivers, we also prevent future harm to our patients.”

Bakken’s enthusiasm about CANDOR comes from what she believes will be a safer—and more supportive—environment for both patients and caregivers. “Patients in organizations that have CANDOR in place say it is healing for both staff and patients,” she says.

—Linda Picone, editor of Minnesota Medicine
sions or misjudgment played a role. The CANDOR toolkit has resources from established programs to help clinicians and the members of health care systems get back as close as possible (or in some cases, better than before, having grown from the process) to the effective, caring state that they had prior to the adverse outcome.

- **Conduct investigations from a systems analysis approach.** The reason for using a systems approach is that managing individual performance alone doesn’t ensure that an adverse event won’t happen again with a different provider. To strengthen system accountability, we need to learn what happened, why it happened, what normally happens and what applicable procedure(s) are required. Only then can we learn why errors were made and how we can implement policy, process and improvement mechanisms to prevent the same errors from happening again.

- **Support education based on learning.** All too often, we only learn about preventable causes of medical harm after the harm has occurred. Building a robust education platform based on analysis of adverse events will protect the next patient from harm. The education should be case-based and interactive and involve all members of the health care team. Debriefing following near-misses is an example of case-based education that protects the next patient and improves outcomes.

- **Focus on meeting the patient’s needs and expectations during the resolution process.** Trust forms the basis of the clinician-patient relationship. After an adverse outcome, it is essential to maintaining trust that there is an explanation of what occurred and what actions are being taken to prevent this in the future as well as an apology when appropriate. Although financial compensation is not applicable in all situations, CANDOR does encourage fair compensation to individuals harmed in the process of receiving medical care when it is a result of clinician or systems error.

While CANDOR was designed as a framework for hospitals, the principles it is built upon can be applied to other medical settings. The CANDOR toolkit training modules can be adapted and customized to meet the needs of different organizations. It is not a one-size-fits-all panacea for medical harm and the stress that follows for patients, families, clinicians and systems, but it can be an effective tool if used correctly by a team that understands it. Ultimately, the goals of this process are to maintain the clinician-patient relationship, increase patient satisfaction, improve patient safety outcomes and have fewer medical liability claims. MM

Alan Lembitz, MD, is the chief medical officer of COPIC, which provides medical liability and malpractice insurance.

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