MedStar Health
Institute for Quality and Safety

Communication and Optimal Resolution: CANDOR

Gap Analysis Report

xxxxx Hospital

Interviews conducted June 23, 2016

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Introduction to CANDOR

Medical liability plays an important role in the US health care system. An optimal resolution for patients and families affected by harm that could have been prevented by reasonable care is essential, but current processes often cause confusion, frustration and anger for patients. This can diminish the opportunity for hospitals and care professionals to learn and improve from suboptimal care. There is strong consensus that improved communication between providers and patients about risks and harm to which they have been exposed will improve patient outcomes and reduce costs associated with medical liability.

In partnership with the Agency for Healthcare Research and Quality (AHRQ) and the Health Research and Education Trust [HRET] of the American Hospital Association, subject matter experts worked to create a toolkit that provides resources to organizations to assist them in implementing best practices around the prevention and response to patient harm. This project has been labeled the **C**ommunication **and O**ptimal **R**esolution Project; aka **CANDOR**. The project's objective was to create a comprehensive toolkit that will allow hospitals to improve the management of patient safety events by implementing processes that facilitate (1) immediate and ongoing honest and effective communication following patient harm events, (2) event analyses that incorporate human factors assessment, and (3) apology and fair and rapid resolution when appropriate.

The toolkit was implemented in 14 pilot sites in three systems in the United States: MedStar Health [Baltimore and Washington, DC], Christiana Care (Delaware), and Dignity Health (Sacramento and San Andreas, CA area).

Prior to implementation of the operational elements of the toolkit, hospitals seeking to implement **CANDOR** underwent a comprehensive Gap Analysis.

Gap Analysis Process

An important step in implementing the CANDOR process is the gap analysis—a formal assessment of each institution's written policies and procedures and a facilitated focus group-style discussion with a diverse array of stakeholder groups representing the governing body and departments across the institution. The purpose of the gap analysis is to understand current practices and identify strengths and opportunities for improvement as the institution prepares to implement the CANDOR process. During implementation of the CANDOR process, the gap analysis helps to identify and strengthen those areas of opportunity and increase the likelihood that the hospital's CANDOR processes and culture will be implemented and sustained.

The gap analysis process is comprised of three interconnected steps:

1. Review of documentation of organizational practices, policies, and procedures, including a detailed review of recent safety culture and employee engagement survey data.
2. In-person, facilitated focus groups with hospital leadership, staff, and providers, focused on CANDOR practices and in the context of the organization’s policies, procedures and guidelines. The National Quality Forum Safe Practices informed much of the content for the areas of inquiry that are contained in the Analysis below.
3. Presentation of Gap Analysis results, wherein gap analysis facilitators review with institutional stakeholders the results of the gap analysis (a summary of which is contained in this report) and define next steps in the implementation process.

The following report summarizes the findings from steps 1 and 2, document review and focus groups, respectively, of the gap analysis process.

In collecting information during informant focus groups, gap analysis facilitators used a SWOT analysis matrix to identify internal strengths and gaps or weaknesses and the associated opportunities to close those gaps and external threats as they relate to implementing and sustaining CANDOR processes and culture (Appendix A). The SWOT analysis results were used to identify gaps in current practice within each of the CANDOR principles and opportunities to close those gaps. The following report provides a comprehensive analysis of these findings, as well as recommendations for addressing gaps identified.

Gap Analysis Findings and Recommendations

	Yes	In Progress	No	Comments
Are governance/senior leaders regularly and thoroughly briefed on risks and hazards?	X			
Has a safety culture survey been completed?	X			Results were reviewed with leadership as they had become available on the morning of the Gap Analysis.
Is there a system in place for patients to give feedback about the organization's performance?	X			
Do patients and/or families serve on committees and give input to leadership?		X		Years ago there was a patient and family advisory council that was not very effective and was abandoned. It was noted though that the Board has "patients" who sit on it and they are quite active in providing feedback.
Is a patient safety program in place?	X			
Are patient safety improvement committees interdisciplinary?	X			Event reviews have become much more interdisciplinary over the past few years.
Are patient safety, quality, risk, patient experience and compliance functions integrated?		X		Recent efforts have begun to coordinate all of these domains.
Does a "just culture" – in which frontline personnel feel comfortable with reporting and "disclosure" exists?		X		All could describe the Just Culture algorithm but a few stated there is a "perception" of retribution for reporting but none could describe any actual cases of retribution. All personnel described the relationship between frontline nurses and physicians to be exceptionally positive and they stated that positive relationship had been present for several years.
Do board members receive basic teamwork, communication, and patient safety training?	X			

Gap Analysis Findings and Recommendations

	Yes	In Progress	No	Comments
Does leadership designate time to patient safety activities?	X			
Does leadership designate resources to patient safety activities?	X			Some worry that there are not enough personnel available for CANDOR implementation.
Is the safety and quality culture assessed annually?	X			

Gap Analysis Findings and Recommendations

	Yes	In Progress	No	Comments
Were the results of the most recent safety and culture surveys distributed?		X		The results were recently provided to leadership. In the past they have been distributed and acted upon. This year's results identified one particular service that has significant opportunities for improvement – specifically perinatal services where patient safety climate and clinical teamwork questions identified those opportunities.
Are survey findings used to guide process improvement interventions?	X			
Is there a process in place for rapid dissemination of critical process improvements?	X			Process improvements and changes are disseminated quickly and in a variety of ways – email, staff meetings, huddles.
Is there a process in place for identifying, managing, and analyzing adverse events, near miss events, and unsafe conditions?	X			iVos is the event reporting system that XXXX uses.
Does staff have access to a system for reporting adverse events?	X			
Does staff have access to a process for reporting disruptive behavior?	X			
Is a root cause analysis conducted after serious reportable and sentinel events?	X			These are facilitated by the Director of Quality and Risk – all commented on the fair and non-punitive process for those RCAs.
Is a root cause analysis conducted after near miss events?		X		
Does the organization perform at least one prospective analysis per year using a method approved by the organization?	X			

Gap Analysis Findings and Recommendations

	Yes	In Progress	No	Comments
Is the root cause analysis committee inter-professional?	X			Physicians are involved although some stated it is the same small few who are so engaged in this and other patient safety efforts.
Are the number and category of patient safety events tracked in a searchable database?	X			
Are patient safety events searchable or reported out on the basis of race or ethnicity?			X	Such data is not currently available.
Are the costs associated with inappropriate-care related harm events tracked and trended?			X	But there is a well-functioning process for bills and professional fees to be waived or "held" for both the hospital and the professional fees.
Are claims and lawsuits tracked and analyzed for lessons learned?	X			
Are the lawsuits associated with individual physicians tracked within the organization?				Unclear – was not pursued in the questioning.
Is a safety/risk manager available at all times to respond to patient safety incidents?	X			
Is the investigatory process for harm events designed to afford all members the protections of state statutes?	X			
Are patients and families encouraged to report safety concerns?	X			
Do patients "teach back" key information about treatment and procedures?		X		There is variability depending on service and acuity of the procedure.
Are informed consent documents written at or below the 5th grade level?				
Are informed consent documents available in languages other than English?	X			
Are interpreters or readers available 24/7 when needed?	X			This was an area of significant concern for staff. A recent policy change has prohibited staff fluent in the language of the patient from engaging in consent related conversations. Many staff expressed

Gap Analysis Findings and Recommendations

	Yes	In Progress	No	Comments
				unhappiness over this recent change in policy.
Does the organization embrace the concept of “shared decision making”?				Not discussed.
Does the organization employ any methodology to assess the effectiveness of the consent process?			X	
Is there a formal process for communicating unanticipated outcomes in the organization?		X		There is a Disclosure policy from 2004 but it is not consistently followed and needs to be re-written to reflect the CANDOR approach to which Health espouses.
Is there a formal process for disclosing unanticipated outcomes to a Patient Safety Organization [PSO]?	X			
Is information related to disclosed outcomes linked to performance improvements?	X			
Do communications with patients and families include the sharing of facts not otherwise known or knowable by the family?		X		Sometimes but not consistently.
Does the institution encourage expressions of empathy?	X			
Does the institution encourage admissions of accountability for mistakes that have caused patient harm?			X	The Corporate Disclosure Policy from 2004 specifically states that liability is not to be discussed.
Do communications include a commitment to investigate and prevent future occurrences?	X			
Are patients and families updated or provided feedback of the results of the investigation?		X		Inconsistent.
Is an attempt made to communicate effectively within the first 24 hours following an adverse event or unexpected outcome?		X		When the organization knows of the event but there are times when harm events are not known for long periods of time.

Gap Analysis Findings and Recommendations

	Yes	In Progress	No	Comments
Are personnel trained and available 24/7 to respond to unexpected outcomes or significantly dissatisfied patients or families		X		Inconsistent availability of trained personnel and unreliable response to events.
Does a licensed practitioner and/or an administrative leader offer an apology, when appropriate?		X		Not consistently.
Does communication include emotional support for patients and their families?	X			
Have all practitioners agreed to participate in the disclosure program?			X	
Have all of the medical malpractice insurers for hospital and practitioners agreed to the process of response and communication after harm events?			X	However, self-insurance and The Doctors Company have an excellent relationship and are poised to create a more formalized process.
Is early remediation an element of the disclosure process?		X		Sometimes.
Are bills for hospital or professional fees waived if inappropriate care caused harm?	X			When known, xxxxx Memorial Hospital has a very robust process for handling the hospital bills and fees for harm events.
Is there a care for the caregiver program associated with unanticipated events?		X		And not consistently followed. There is a Physician Wellness Program the members of which would like to become more active in delivering care for the caregiver support.
Has the staff had training related to the vulnerabilities of caregivers involved in harm events?			X	Not all staff.
Do staff have the opportunity to participate in event investigations and process improvement initiatives?	X			And the event analyses are conducted using a “fair and accountable” or just culture approach.
Has an organized process to assess behavior related to the event been established?	X			All staff could speak to the Just Culture algorithm that has been used throughout the organization. There some

Gap Analysis Findings and Recommendations

	Yes	In Progress	No	Comments
				concerns from the accountability perspective.
Is supportive care provided to the caregiver within 24 hours of the event?			X	Not consistently.
Do individuals directly involved in events undergo a “fitness for work” assessment			X	
Is follow-up provided for staff involved in harm events?		X		Sometimes.

Gap Analysis Findings and Recommendations

SUMMARY OF GAP ANALYSIS ACTIVITY

Documents reviewed:

Documents for Submission to Reviewers	Documents Provided	
Policies and procedures	Yes	No
a. Identification and reporting of incidents, occurrences, adverse events or complaints	☒	☐
b. Investigation of occurrences (i.e., sentinel events or other triggers for RCA or intense investigation)	☒	☐
c. Complaint/grievance management	☒	☐
d. Disruptive behavior and/or code of conduct	☒	☐
e. Other peer review policies	☒	☐
f. Informed consent or shared decision making	☒	☐
g. Disclosure of adverse events	☒	☐
h. Care for the caregiver, employee assistance, physician wellness	☒	☐
i. Ethics consult triggers	☒	☐
j. Just Culture	☐	☒
Bylaws for medical staff and/or hospital	Yes	No
a. Peer review process	☒	☐
b. Oversight/management of adverse or "harm" events	☒	☐
Organizational safety and/or quality plan	Yes	No
a. FMEAs or other proactive process	☐	☒
b. RCA policies/procedures/processes	☒	☐
Organizational structure	Yes	No
a. Organizational chart showing linkages among safety, risk, quality, credentialing, ethics, legal, and claims	☒	☐
b. Patient and Family Advisory Council: membership and bylaws	☒	☐
Safety survey or other quality survey, such as patient satisfaction results	Yes	No
a. Safety Attitudes Questionnaire (SAQ)	☐	☒
b. AHRQ Hospital Survey on Patient Safety Culture (HSOPSC)	☒	☐
c. Hospital patient satisfaction survey	☒	☐
d. Employee engagement surveys	☐	☒
Board minutes or reports related to quality and safety	Yes	No
a. Reports related to demographic and descriptive data of vulnerable populations	☐	☒
b. Quality and safety outcomes based on race, ethnicity, and language	☐	☒

SUMMARY OF GAP ANALYSIS ACTIVITY

Documents reviewed: Seventeen [17] policies, procedures, and templates along with the most recent safety/employee engagement survey results. Four other Hospital Gap Analyses were also reviewed.

Interview sessions: Seven [7] sessions including:

- Senior leadership
- Frontline nursing
- Frontline ancillary staff
- Medical staff leadership
- Quality and risk management staff
- Director/manager leadership group

Over 100 personnel from Hospital engaged in the interview sessions.

Common Themes from the interview sessions based upon the "Joint Commission Center for Transforming Healthcare" High Reliability Domains [Safety Culture, Performance Improvement and Leadership] and Staging: Beginning, Developing, Advancing, Approaching

Safety Culture

Trust & Teamwork: Advancing. The CEO and other clinical leaders has established a trusting environment amongst staff and model behaviors and champion efforts to eradicate non-professional behaviors. Relationships are excellent between physicians and nurses along and other ancillary staff.

Accountability: Advancing. All of the managers interviewed give high priority to establishing and maintaining a just culture in the organization. All clinical departments have begun to recognize and adopt equitable disciplinary procedures such as "just culture".

Identifying Unsafe Conditions. Advancing. With the use of the reporting system staff in many areas recognize and report unsafe conditions and practices before they harm patients, however concerns were voiced by some that the process for reporting feels or seems "punitive".

Gap Analysis Findings and Recommendations

Strengthening Systems. Advancing. System weaknesses have been identified and prioritized for improvement in several instances. The staff reported that the process for this has improved substantially over the past few years – due in large part to the excellent work of the Director of Risk/Quality.

Assessment. Approaching. Safety culture measures are part of strategic metrics that are reported to the Board and senior leadership and improvement initiatives are underway to achieve maximal fully functional safety culture.

Performance Improvement

Methods. Developing/Advancing. There has been recent exploration of robust process improvement methodologies with the beginnings of leadership commitment for the broader application of these methods.

Training. Advancing. All of the staff, including the non-clinical and clinical frontline staff were able to articulate "just culture" principles in detail.

Spread. Advancing. Pilot projects such as fall prevention have been effectively spread throughout the organization with success.

Leadership

Board. Advancing. It is reported that the corporate and community Boards are engaged in the development of quality goals and the quality plan; they regularly review adverse events and progress on quality goals.

CEO/Management. Advancing. The CEO and other members of the "C-Suite" lead in the development and implementation of a proactive quality agenda.

Physicians. Advancing. Physicians often lead and champion quality improvement activities but there are some gaps within some clinical areas. They do hold each other accountable and there are few instances of unprofessional behavior form their ranks and the nurses confirmed this.

Quality Strategy. Advancing. Through strong corporate leadership, Quality is one of the organizations top 3 or 4 strategic priorities and all of the leadership and staff could speak to that.

Information Technology. Developing. The current informatics systems support some of the improvement efforts but it is a significant area of opportunity.

Gap Analysis Findings and Recommendations

Other Common Themes from the interview sessions:

Culture

- From a hierarchical perspective, only a few physicians are feared.
- Some "reporting" does occur but not between physicians and nurses.
- Some units suggested that their "leaders" discourage reporting in the belief that higher reports means worse unit.
- Ubiquitous feeling that organization is ready for all elements of CANDOR.
- Some fear that submitting a report is "writing someone up – especially someone they will see at the grocery store or at dinner that same night.
- Root cause analysis is fair and focused on improvements.

Teamwork

- There were many descriptions of the exceptionally close collaboration amongst physicians and nurses at unit level and beyond – including leadership. This feeling was expressed by all of the groups interviewed from the frontline to the highest levels of leadership. In comparison to all other Hospitals visited during the Gap Analysis process the relationship between physicians and nurses at XXXX was the most positive.
- Desire for closer collaboration between different units at the staff level was expressed.

Requests or "wish lists" going forward

- Scripting and practice around difficult conversations related to patient harm events.
- Extend CANDOR to the outpatient clinic area and include training around less serious events.
- Many staff expressed unhappiness over new policy related to bilingual staff being prohibited from engaging in shared decision-making or consent decisions.
- Possible creation of a "good catch" award was considered a good idea.
- Desire for more lean/six sigma activities with improvement in the ordering of necessary diagnostic tests.
- Many requested more "space" for patients and other activities.

- More "on unit" pharmacy engagement.
- Build upon the exceptional physician-nurse collaboration.

SWOT [Strengths, Weaknesses, Opportunities and Threats] Analysis:

Strengths

- Committed, dedicated and well-respected leadership at all levels – medical, nursing, finance, operations, quality and safety.
- Nurses feel very empowered to "stop the line".
- Very close collaboration between medical staff and the nursing/ancillary staff.
- Regular huddles after serious events and taking a "pause" with family present when death occurs.
- Excellent coordination.
- Close ties with the local community at many levels.
- Nurse managers are available now 24/7 for responding to unexpected events.
- Physician medical malpractice insurance company is NOT perceived as a barrier.
- Frontline staff report great joy in working with their colleagues.
- Physicians "own up" when unexpected events occur.

Weaknesses

- Inconsistent engagement and participation of all departments in responding rapidly to unexpected outcomes and engaging in event review and improvements - some reported lack of coordination and cooperation between units on signficant cases.
- Data related to potential disparities related to race, ethnicity and preferred language is not captured or analyzed.
- Do not consistently engage patients or families in obtaining their perspective for event reviews.
- **The "bench" for personnel to support CANDOR-type activity is not deep.**

Gap Analysis Findings and Recommendations

Opportunities

- From the Patient Safety Climate and Teamwork Survey there are some important opportunities for improvement within the perinatal services – this may be important when moving forward with CANDOR implementation.
- Improve feedback after event reporting.
- Desire for situational awareness between departments.
- Currently no measurement for health disparities based upon race, ethnicity or preferred language.
- More near miss events reported and acted upon.
- Would like to see Wellness Committee linked with physician peer support or "care for the caregiver activities".
- There are retired physicians who could be a great source of peer support.
- Many view the improved engagement of patients and families engagement as an excellent opportunity.

Threats

- Recent developments suggest some modification to the tight relationship between hospital and foundation.
- Personnel making promises they cannot keep to patients and families after harm events.
- There is a fear that -Corporate will overwhelm the team with unreasonable deliverables and without adequate resources.
- Small, tight knit community where everyone knows everyone else creates need for careful balance in managing harm events in a way that supports organization's reputation.
- Limited space to do the work they love doing seems to be an issue.
- With a small number of passionate, skilled and committed personnel involved in Quality and Patient Safety efforts any struggles with succession planning will be a serious threat to successful and sustainable implementation.

Conclusion and Recommendations for Next Steps

Overall, the approach to quality and patient safety at xxxxx Hospital seems to have matured and improved substantially over the past several years. Of the more than CANDOR Gap Analyses conducted to date, the application to Just Culture principles is at a stage not found in any of the other organizations. Staff express passion and enthusiasm about their work and feel a tight bond with their colleagues, their patients and their community. The organization has been evolving over the past few years, with many changes identified in key areas to highlight as core CANDOR-related strengths. These include:

- From the front lines up to the highest levels of leadership that is a clear commitment to just culture approach to unexpected outcomes, transparency and the principles of the CANDOR process.
- Physician leadership is highly engaged, knowledgeable about patient safety and are very supportive of the CANDOR initiative.
- Competent and qualified people are now in place with the skill set to engage in implementation of CANDOR.
- The entire leadership is not only well respected but they are also active and engaged and have patient safety and quality care as top priorities.
- The organization has made a substantial investment in Just Culture training and the results are clear - they are well on their way in fully operationalizing it down to the level of the bedside in all areas.

Key stakeholders and participants consistently discussed these characteristics throughout the one-day interview process.

In addition to the areas of strength, there were several areas that should be highlighted as opportunities for improvement or key threats to implementation or sustainability of CANDOR. These include:

- The Corporate Disclosure Policy should be re-written to reflect to intended practice at Hospitals.
- Opportunity to engage patients and families in event review and process improvement efforts seems to be available and desired.
- The number of personnel available for key CANDOR functions is limited and the need for an effective succession plan is evident.
- Improved feedback process for event reporting including the development of a “Good Catch” program would likely improve the reporting of near misses, unsafe conditions and harm events.
- The heretofore-close collaborative relationship between hospital and foundation seems to be “at risk”.
- -Corporate will need to be mindful of not overwhelming the team with unreasonable deliverables and without adequate resources during the period of CANDOR Implementation.

Initial Next Steps

- Re-write Disclosure Policy.
- Identify and charge a small working group to find candidates to serve on a patient communication consult/coaching service and a care for the caregiver [CFC] team – this may include identifying interested retired physicians in the community.
- Integrate those on the communication consult service with other groups engaged in quality, safety, risk, and patient experience.
- Engage the Physician Wellness Committee in the development of the Physician Peer Support component of the CFC program.
- Conduct a communication assessment of potential candidates.
- Establish an “action plan” to operationalize the rapid response to harm events consistent with XXXXX Memorial Hospital current patient safety and patient experience program.
- Conduct Communication Training for engaging patients and families following harm and for providing emotional support to caregivers.

CANDOR Team Roles

Team Role	Responsibilities	Attribute/Suggested Participants
CANDOR Implementation Team		
CANDOR Implementation Team Lead	Organization-wide implementation of CANDOR. Reports to Executive Leader(s).	Influential senior leader who has the authority to make necessary decisions, and enthusiasm to oversee program implementation. Suggest: CMO, CNE, etc.
Culture Team		
Culture Team Lead	Oversight and administration of SCORE/safety survey process.	High level leader with strong support and skills to oversee survey administration and adoption and implementation of strategies to improve organizational culture.
Culture Team Members	Supports culture team leader in administration, analysis of culture survey process.	Multidisciplinary participants. Persons known to physicians and staff. Persons who have expressed interest in survey process and can influence staff/physician completion/participation. Champions of Just Culture principles and philosophy.
Event Reporting, Evaluation, Analysis Team		
Event Response, Analysis Team Lead	Implements event reporting, investigation and analysis process. Reports to CANDOR team leader.	Person with authority and accountability to lead adverse event response process. Recognized by staff as supportive and fair in event analysis process. Knowledgeable of just culture and human factors principles. Suggest: Director of Risk Management.
Event Response, Investigation, Analysis Team Members	Supports event response team leader efforts. Participates in and able to facilitate event response, investigation and analysis.	Persons with knowledge of event analysis process, exhibit curiosity in understanding contributing factors, able to evaluate objectively and absent bias. Understanding of human factors and just culture principles. Suggest: Risk management staff, claims staff, clinical leaders.
Communication and Transparency Team		
Communication Team Lead	Provides support and oversight for the Communication and Care for Caregiver process. Reports to the CANDOR team lead.	Influential and positive communicator who has participated in communication and disclosure training. Suggest: Medical Director, CMO, Nurse Exec, Risk Manager.

Team Role	Responsibilities	Attribute/Suggested Participants
Communication/Transparency Team	Champion the communication and disclosure process. Participate in communication assessment and simulated training in disclosure. Reports to the Communication team leader.	Influential and positive communicators who have been/will be trained in disclosure process. Suggest: Physician leaders, nurse leaders, risk management, patient safety experts.
Care for Caregiver Team		
Care for Caregiver Team Lead	Oversees implementation of the Care for Caregiver program. Reports to the CANDOR team leader.	Influential staff who may have experienced a second-victim event and express desire to help/support others.
Care for Caregiver Team/ Peer Supporters	Assists the Care for Caregiver team leader in developing and implementing the Care for Caregiver program.	Suggest: Physicians (active and retired), nurses, residents, social services, chaplain, HR staff.
Early Resolution Team		
Early Resolution Team Lead	Oversees implementation of the Early Resolution process. Reports to CANDOR team leader.	Suggest: Director, risk management, legal counsel, claims staff.
Early Resolution Team Lead	Assists the team lead with development and implementation of the resolution process.	Suggest: Risk management staff, claims, legal staff, patient representatives.
Auxiliary Team Members		
Physician Champion	Reinforces goals of CANDOR process, educates clinical staff about the program. Serves as liaison to promote and support implementation across medical staff.	Physician leader who is influential and well respected.
Nurse Champion	Reinforces goals of CANDOR among nursing and allied health staff. Exhibits behaviors consistent with CANDOR principles.	Suggest: CNE or designee.
Risk Management Champion	Reinforces goals of CANDOR, educates risk, claims, legal staff about the CANDOR process. Serves as liaison to promote and support implementation with risk, legal and claims staff.	Suggest: Director, risk management, risk manager, patient safety officer.
Direct Patient Care Staff	Serves as liaison to promote and support CANDOR implementation with frontline clinical staff.	Suggest: Nurse manager, charge nurse, clinical educator, nursing supervisor.
Indirect Patient Care Staff	Serves as liaison to promote and support CANDOR implementation with indirect patient care staff.	Suggest: Social services, pharmacy, lab, radiology, patient relations, security, guest services.

Team Role	Responsibilities	Attribute/Suggested Participants
Patient and Family Advisors	Attends team meetings and supports team on specific activities. Provides the voice of the patient throughout the program development and implementation process.	Suggest: Patient and family advisors, patient liaison.
Marketing/Communications	Attends team meetings as needed. Assists with promoting CANDOR across the organization and to patients/families.	Suggest: Public relations, human resources.