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Informed consent: Patient-centered communication strategies

By Sandra Myerson, President and CEO, SLM PX Consultants, LLC

Physicians regularly obtain informed consent from patients for diagnostic studies, invasive procedures and end-of-life care. The original legal requirement for informed consent was defined as the process by which a patient learns about and understands the purpose, benefits and potential risks of a medical or surgical intervention, and then agrees to receive that treatment or intervention.[1] The definition of informed consent, along with the process of obtaining informed consent, has evolved. Today, informed consent is a communication process in which the physician provides the patient with information about all possible treatment or decision options and then the patient selects the option that best fits their goals, values and preferences.[2]

To achieve patient-centered communication, physicians must develop a complex and sophisticated communication skill set not typically taught or learned in medical school, including genuine personal engagement and emotional involvement, awareness of personal reactions to comments made or issues raised by patients, and appropriate discernment to choose effective words and phrases.[3] The following outlines a review of patient-centered communication strategies specific to informed consent and shared decision-making with a mentally competent patient. When physicians learn and employ these strategies consistently, patients become active participants in the informed consent process; better informed decision-making results in increased patient knowledge, increased patient self-efficacy, and better adherence to treatment regimens.

Continued on page 2

1. **Preparation.** Considering all the details in advance of the patient's appointment will set the stage for a successful discussion. Review all diagnostic results and have them readily available. Ask your patient to invite a family member or close friend whose opinion matters and who can provide support. Schedule sufficient time to discuss all options, answer questions, and assure the patient comprehends the information; consider scheduling a second meeting to give the patient and his or her family time to reflect and consider all options. Determine the need for an interpreter if language barriers are present, and provide a qualified medical interpreter for the meeting if the patient's primary language is not English; do not rely on the patient's family member or friend to interpret complex medical terms.[4]

2. **Adopt health literacy universal precautions.**[5] Avoid using medical jargon. Physicians know complex medical and scientific concepts and converse with their colleagues and other clinicians in a language that is foreign to patients. Many clinicians struggle explaining diagnoses and treatment options in plain language. Pay close attention to the words you use and replace clinical or medical terms with simple non-technical words to describe and explain options. Consider using visual aids to support the discussion and improve the patient's understanding. Visual aids could be low-tech handmade drawings, a three-dimensional anatomic model or high-tech solutions, such as interactive video-based illustrations. Speak slowly and repeat key points. Break the information up into manageable portions.

3. **Employ teach-back technique to assess comprehension.**[6] Weave the teach-back technique into the informed consent process. Ask the patient to paraphrase the primary message you just delivered to assure they heard your explanation as intended. This will provide an opportunity to clarify things if the patient did not understand. "Just to make sure I explained things well, can you tell me what you understand will happen if you choose to have this procedure done?" Avoid using closed-ended questions, such as "Do you understand?" or "Do you have any questions?" Patients are reluctant to admit to their physician when they do not fully understand or need clarification, resulting in consent that is not fully informed.

4. **Explain benefits, harms and risks of all options.** Physicians may have a bias toward one option over another, or assume a patient will select a particular option based on previous interactions with them. Present all treatment options regardless of your assumptions or whether the patient's insurance covers all of them. Consider the patient's financial situation during the shared decision-making process. Acknowledge that uncertainty regarding the outcomes of the options exists. Share the limitations of the evidence. For example, "Some research shows this treatment is effective, and other studies indicate that it may not be as effective. We don't know how effective it will be for you." Some benefits and harms will be time limited; be specific about how long you expect a benefit or harm to last. "You won't be able to drive for a month." Include information that seems obvious or minor to you but that the patient may feel is pertinent. "Your skin around the area we cut will be tender for a few days."

5. **Elicit the patient's values.** To learn what is important to the patient and to help them choose the option that fits them best, it is important to ask open-ended questions that will elicit information about the patient's fears, preferences, and motivations. "What matters most to you?" "What do you hope to achieve?" Ask for their thoughts about the various options presented. "What are some of the pros and cons of the options we just reviewed?" Identify emotions or facial expressions the patient exhibits. He or she may appear worried, overwhelmed or sad. Naming the emotion you see will help improve the trust and rapport you have with your patient and help guide the conversation so the patient selects the option that fits their values. "You seem overwhelmed by all this information and the various options." "Help me understand what you're thinking so we can work through this together."

6. **Body language and tone of voice matters.** Sit facing the patient at eye level. Use a tone of voice that is calm with a slow and measured rate of speech. Lean in and establish eye contact. Your demeanor will instill confidence and ease some of your patient's anxiety, which will enable them to hear and absorb the information you are about to share. Patients' need for repeated information or their unrealistic expectations of the outcomes associated with various treatment options can be exasperating; pay attention to your emotions and keep them in check. If your patient continues to expect or demand unrealistic outcomes, consider making a referral for a second opinion.[6]

7. **Engage the family member or trusted friend.** Often stressed by their situation, diagnosis and/or illness, patients may not hear everything you say, may not comprehend clearly, or they may fail to remember important information. Encourage your patient to bring

a support person or family member with them to their appointment to lower their stress, help the patient process information shared, and to ask questions the patient may not think to ask. Be sure to find out who has accompanied the patient and how they are related (spouse, friend, etc.), and thank them for joining the patient for this discussion. When your patient struggles with identifying what matters most to them, or with weighing the pros and cons of different options, the family member can often add insight and perspective that will facilitate the discussion and decision-making process.

8. **Document the discussion.** Ensure that you document all significant portions of the informed consent process, including who was present, any drawings, models or diagrams you reviewed, questions the patient or family member asked, all options discussed, and your use of teach-back to verify the patient understood the risks and benefits of options presented.[7] If you used an interpreter during the informed consent discussion, make a note in the record and have the interpreter sign the informed consent form. Finally, document the patient's decision, including when patients choose not to have a treatment or procedure. For both the patient's protection and your own, consider documenting every informed consent discussion in the patient's record, regardless of whether you use an informed consent form.

Developing and improving a patient-centered communication style requires thoughtful preparation, practice with new techniques, and introspection. Enhancing your repertoire of communication skills specific to the informed consent process will improve the quality of communication with your patients, help to create a trusting and respectful relationship, align expectations, and reduce your exposure to malpractice litigation related to allegations of lack of informed consent.[8]

A mnemonic, such as **ABCDEF** below, may be useful in guiding and documenting your review of options with the patient: [9]

- **A. A**lternative therapies available
- **B. B**enefits of proposed therapies
- **C. C**ommon but not devastating risks
- **D. D**evastating but not common risks
- **E. E**xtra considerations specific to this patient
- **F. F**acial expressions, body language, and questions

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Healthcare Risk Management

Rapid response teams: Reducing risk through early response

By Debbie Lepman, MPH, BSN, RN, CEN, PHN,
Sedgwick Nurse Consultant

Rapid Response Teams (RRT), also known as Medical Emergency Teams (MET) or Medical Emergency Response Teams (MERT) were founded to provide an immediate and organized approach to patient decline outside the critical care environment. When caregivers do not recognize nor understand the early warning signals of patient deterioration "failure to rescue" occurs. RRTs have been designed to support and "rescue" a patient when caregivers fail to recognize signs and symptoms leading to imminent danger and potentially life-threatening situations. This form of organized response has become an established standard of care following endorsement by the Institute for Healthcare Improvement (IHI) in its 5 Million Lives Campaign.[1]

Many times patients may experience what "appears" to be a sudden cardiac and or respiratory event. However, subtle but

progressive changes often precede these events. When these changes or signs are not recognized and allowed to progress, the patient remains untreated leading to a critical situation requiring "full on" resuscitation. When this chain of events occurs, the ability to respond in a timely and appropriate manner is compromised, leading to delayed intervention and a life-threatening, possibly irreversible situation for the patient.[2]

Risk factors

Several elements contribute to a lack of appreciation and appropriate response to declining clinical status:

- Lack of complete patient information (patient history, change in vital signs, patient complaints)
- Absence of goal planning (nursing goal, patient directed goals, patient assessment)
- Poor, ineffective communication (between staff, patient to staff etc.)[3]

Rapid response

The purpose of the RRT is to bring to the bedside the clinical and critical care experience necessary to address changes in a patient's physical condition before it deteriorates to a life-threatening, irreversible state.[4] The RRT supports both the patient and the staff in recognizing what is wrong and then taking the necessary action to address the patient's needs as quickly as possible. In so doing, the team's priority is to stop the clinical chain of events leading to complete patient compromise, transfer to critical care, and/or possible death.

The RRT is an organized and dedicated group of healthcare providers (nurses, physicians, respiratory therapists, etc.) readily available to respond to emergency notification outside a critical care unit.[5]

The group has specialized training and follows established policy and procedure to address urgent and emergent situations in an effective and timely manner. The keys to success are the team's availability and ability to respond as quickly as possible to an acute situation outside the critical care unit, and provide the specific critical care intervention needed.

Rapid response design

Rapid response or medical emergency teams may be developed differently based on the needs and makeup of an individual organization. Several different models of rapid response teams exist and a 2006 consensus conference advocated use of the term "rapid response system" (RRS) as a unifying term.[6] It is important when designing a rapid response program that the organization critically evaluate its needs and identify prioritized goals. These factors are essential to ensure the program design is appropriate and robust enough to support an effective and successful response system. The initiative promotes patient safety, survival and quality of life, but also brings a financial cost and human resource investment to the organization. Please see Table 1.

Table 1. Rapid response system models

Model	Personnel	Duties
Medical Emergency Team	Physicians (critical care or hospitalist) and nurses	• Respond to emergencies
Critical Care Outreach	Critical care physicians and nurses	• Respond to emergencies • Follow up on patients discharged from ICU • Proactively evaluate high-risk ward patients • Educate ward staff
Rapid Response Team	Critical care nurse, respiratory therapist and physician (critical care or hospitalist) backup	• Respond to emergencies • Follow up on patients discharged from ICU • Proactively evaluate high-risk ward patients • Educate and act as liaison to ward staff

Models of Rapid Response Teams (Agency for Healthcare Research and Quality, Patient Safety Network, July 2016)

Early warning scoring systems have been developed to more reliably identify patients in trouble and trigger a standard communication system to call the RRT to respond quickly – often within 5 minutes.[7]

Rapid response documentation

A standardized documentation form to record RRT response activity is an essential tool for recording events and to identify opportunities for improvement, identify best practices, and facilitate recognition of staff and team members on a job well done.

Examples of documentation forms can be found on the Institute for Healthcare Improvement (IHI) website: www.ihi.org/resources/Pages/Tools/SampleRapidResponseTeamDocumentationTool.aspx. Forms and resources are also available through the American Heart Association's Get With The Guidelines(r)-Resuscitation Patient Management Tool: http://www.heart.org/HEARTORG/Professional/GetWithTheGuidelines/GetWithTheGuidelines-Resuscitation/Get-With-The-Guidelines-Resuscitation-Patient-Management-Tool_UCM_314501_Article.jsp#.WdS2d1uPLIU. Forms and templates may also be found on the National Registry of CPR.[8]

Recommendations

Institutions deploying RRTs report a decrease in cardiac and respiratory arrests outside their critical care units. They also describe a decrease in overall hospital mortality. However, overall effectiveness of RRTs remains controversial due to variability across studies.[9]

Though controversial, the patient safety officer and risk manager need to consider the risks of not implementing an RRT. Patient deterioration without recognition and response is a top patient safety issue. The use of RRTs is producing positive clinical results, and is benefiting hospitals' organizational cultures and staff morale.[14] Positive results have included:

- 50% reduction in non-ICU cardiac arrests[10]
- Decreases in post-operative emergency ICU transfers (58%) and deaths (37%)[11]
- A reduction of cardiac arrest prior to care transfer to critical care (4% versus 30%)[12]
- 17% reduction of cardiopulmonary arrests (6.5 versus 5.4 per 1,000 admissions)[13]

Not implementing an RRT places an organization at risk for the opportunity to gain such results, as well as non-compliance with the new IHI standard and participation in the 5 Million Lives Campaign. Patient safety and risk management leaders, demonstrating due diligence, will do well to promote an organized and timely response system and recommend incorporation of this strategy in hospital policies and procedures, daily care routines and patient safety goals.

Engaging patients and families

The concept of Condition Help or Condition "H" is an initiative that allows patients, families and significant others to literally call for help and seek immediate assistance from the RRT.[15] This occurs when the patient feels they are in trouble, "not being listened to," and need help. There is no delay deliberating the seriousness or validity of the call; the team responds to the patient and promptly addresses concerns. When an acute situation is present, the RRT goes into action and takes appropriate measures. If there is no immediate issue, the team documents the call and moves on to their next priority. In this environment, no call is a bad call and all patient requests are received in a positive manner regardless of their severity.

Conclusion

As further study and research continues on the efficacy and merit of RRTs, most hospitals have implemented some form of the program. This is based on the 2008 Joint Commission National Patient Safety Goal that required healthcare institutions to develop a system where staff directly request assistance from skilled caregivers when a patient's condition worsens.[16]

Hospital staff, particularly nursing, have embraced RRT. With the presence of such a team, nurses no longer feel alone and "on their own" when something is seemingly wrong with their patient. Skill and experience are imperative when assessing a patient's situation. Addressing the issue promptly with clinical data and evidence is key to effective management. The RRT provides the skill and knowledge necessary to support staff in securing clinical resources needed at the bedside. Reducing risk of patient harm can be accomplished through a system of organized recognition and response.

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10 STRATEGIES FOR SUCCESSFULLY RESOLVING A MEDICAL MALPRACTICE CLAIM

By Jayme T. Vaccaro, J.D., Vice President, Specialty Claims Operations, Sedgwick

From never being afraid to try a case, any case, to knowing what ultimately motivates the plaintiffs, thinking outside the box and utilizing creativity can be a mantra for successfully resolving medical malpractice claims. In a series of ten articles, Jayme T. Vaccaro shares time-tested strategies for resolving a medical malpractice claim.

Ten strategies:

1. **Never be afraid to try a case – any case**
2. **Always be aware of the plaintiff's attorney vulnerabilities – leverage**
3. **Always know where your codefendants lie and wait – friend or foe**
4. **Use your tools – from high/lows to bifurcation**
5. **The courtroom is sometimes not the place – alternative forums**
6. **Know when to hold – and know when to fold**
7. **Know what the plaintiff wants out of the case – the sweet spot, and it may not be money**
8. **Back to basics – know your case inside and out, legal, medical and the like**
9. **Anyone can help you mediate – from the judge to the structured settlement representative**
10. **Understand risk appetites – client/insured/defendant**

Read strategies 1-4 in our recent *Risk Resource* newsletters, archived at: http://www.sedgwick.com/news/Pages/newsletters.aspx. In this issue, we will explore Strategy 5.

Strategy 5: The courtroom is sometimes not the place – alternative forums

I often get asked, "why is there such a focus on trials when so many cases never get to a courtroom?" Admittedly, in our industry, 80% or more of claims and lawsuits go away with no indemnity payments. Only 5-15% of lawsuits are tried. Why such a focus on the courts and jury trials?

First, medical malpractice claims are generally resolved in the fierce world of civil litigation. Jury verdicts and judges have a tremendous impact on case value. While we of course do not want to pay full jury verdict value if we are settling a case, we look to trials and how facts and money damages played out to gauge settlement value. The goal is to pay less than jury verdict value, but the court system – or judges by way of, say, a mandatory settlement conference – is not always the best place to resolve a case.

There are other opportunities to resolve our matters outside the courtroom short of trial, but with other less traditional participants and approaches. We often look to the judge or formal mediators to resolve our legal disputes. Civil judges are quite busy and mediators are quite expensive. Looking around us, who else can facilitate a resolution? Considering all aspects of the case, are there angles or less formal forums than the courtroom that would encourage a mutually acceptable resolution?

Take the structured settlement annuitant. Oftentimes, they've worked for both the plaintiff and defendant and are experts on financial matters. They are very familiar with each side, as well as damages and detailed facts on the needs of the plaintiff.

What happens when codefendants all agree to settle a case, but cannot agree on apportionment? Can they settle the case with the plaintiff, but go to private arbitration to resolve their differences on allocation between themselves?

What about holding a meeting with the plaintiff that will be less formal and more appropriate for having a straightforward, less intimidating resolution discussion? If we get creative and become sensitive to people and places that better facilitate resolution, the opportunities are endless. Let's take a look at a better forum and approach to resolution.

Example: A gentler, kinder approach to a mother's heart

The patient, an 8-year-old child, fell and scraped her knees and thighs while riding her bike. Her mother brought her to the emergency department. Her scrapes were examined, cleaned and bandages were applied. No oral antibiotics were prescribed but topical antibiotics were placed on the exposed areas. The patient was discharged with instructions to return to the emergency department if the rash, fever or pain worsened. A check-up by the family pediatrician was recommended in three days or sooner if the condition worsened.

The following morning and afternoon, the child felt sleepy, lethargic and had a slight temperature. The mother called the pediatrician who asked the mother to bring the child in as "he could not diagnose her on the phone." The mother did not bring her daughter in to the family pediatrician. In the early hours of the morning, the mother checked on her daughter to find her nonresponsive with a high fever and blotchy skin. The child was returned to the emergency department where she was diagnosed with septic shock and subsequently died.

As the medical malpractice claim developed, it became apparent the mother felt tremendous guilt and was manifesting her guilt by pursuing publicity, taking a position that no settlement and only a trial would satisfy the wrong done to her child. She wanted the physicians, hospital and others involved to face public shame given what she felt was substandard care.

The number one witness for the defense was going to be the mother. She did not bring her child to the pediatrician and did not bring the child back to emergency department sooner. She would eventually have to take the stand and explain to a jury why she did not bring her daughter back in for care.

It became apparent the relationship between the mother and father was strained due to the litigation. The mother's guilt and crusade was leaving the surviving brother/son lost and all but forgotten. It also became evident the father wanted to put the entire matter behind him and have the family learn to live again and rebuild their lives. The plaintiff's attorney felt it would be best to resolve the matter for this family so they could begin to heal.

A meeting was suggested with the defense and seven plaintiff's counsel, mother, father and physician defendant. It was a meeting to let the mother know that, while the physician did not commit malpractice, he felt tremendous sympathy for this family. He had children; he couldn't imagine the pain and sorrow of losing a child.

The discussion centered on how hard we work at being the best parents we can be. How much we love our children and do all in our power to protect them. How even if things could have gone differently, no one should judge a parent who is doing their best and in a brief moment a judgment call ends tragically. Most importantly, no family deserves to be in a courtroom that could forever find a mother even partially at fault when we knew she was doing her best. Finally, forgiveness - forgiveness of oneself, the physician and the hospital was key.

Within two days of the meeting, the family dismissed the case and no payment was made on behalf of the defendants. The family moved to another state and started a new life. The defense counsel stated it was one of the most emotional, intense and gratifying meetings he'd ever had in his 40-year practice.

Conclusion

We are hearing a lot about empathy, "sorry works" and other early resolution approaches for medical malpractice would-be cases. As an industry, we see as few as 3% of incidents convert to claims or lawsuits, and 75% to 85% of our claims and lawsuits go away with no indemnity payments. (For extensive studies on MPL stats see PIAA, AIG, Marsh, Risk Authority, yearly reports).

If we start resolving incidents earlier, we will certainly upset these impressive statistics. On the other hand, the program that can spot the incidents and claims that will convert, and once converted, will end up in an indemnity payment is in fact the more skilled claims program. There are arguments that, by resolving matters earlier, we will avoid costly lawsuits and, more importantly, "do the right thing" for the injured patient. Again, with such a high dismissal rate with no indemnity payment, this may or may not play out. Here are a few possible reasons for the high dismissal rate:

- We are settling those cases that need to be settled
- We are trying cases that should be tried
- We are practicing great medicine and jurors know it

If however, we want to resolve those cases we will eventually pay indemnity on, doing so earlier in an alternative forum like the one discussed above will satisfy the empathy we all have for mistakes. It will also preserve the great statistics our field has earned due to hard working and caring providers. The second victim in a medical malpractice case is the provider. They live with a case on their claims histories. If we rush to resolve a matter when we could have maintained the dismissal with no payment, we forget the empathy needed for our providers.

With Strategy 5 comes a tall order: alternative forums which include earlier and creative resolutions and, most importantly, resolutions the patient, provider and industry can live with.

Next time, Strategy 6: Know when to hold – and know when to fold

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Communication and resolution programs: Where are we now?

By Kathleen Shostek, RN, ARM, FASHRM, CPHRM, CPPS, Vice President, Healthcare Risk Management, Sedgwick

In recent years, some innovative healthcare leaders and organizations have developed and implemented formal communication and resolution programs (CRPs) that, when combined with advances in patient safety, exemplify fairness and build trust. The intent of CRPs is twofold: 1) to lower malpractice costs and 2) to maintain patient trust in the healthcare system.

One program in particular, implemented by the University of Michigan Health System (UMHS), is multifaceted and involves not only open communication about adverse events, but also the following:[1]

- A critical investigation of the event to determine if the care provided met the standard of care and was reasonable under the circumstances
- An apology to the patient
- Early offer of compensation or settlement when the care fell below standard or was deemed not to have been reasonable

Known as "The Michigan Model," the UMHS program has reported success in reducing malpractice claim costs. An important aspect of this model is the critical investigation by the risk management department at UMHS that leads to a multidisciplinary committee review of the event (or claim) to determine whether the care provided was medically reasonable and if the care had an adverse effect on the patient's outcome. The event may or may not be referred to peer review, but it is always evaluated for learning opportunities and quality improvement so as to prevent a similar event from occurring again. It is important to note that the outcome of the investigation is communicated to the patient. When the care was deemed to meet the standard of care and/or reasonably provided, no compensation is offered and if a claim is brought, the care is rigorously defended.

Other factors favorable to the success of the UMHS program is that under Michigan law there is a six-month waiting period before the patient can file a lawsuit. This provides time for the investigation and committee review to take place. Also, the committee's review of the event is protected from legal discovery in that state. After several years of refinement, UMHS reported a claims rate more than 25% lower after implementation of its program and a decrease in average monthly cost rates for total liability, patient compensation and non-compensation-related legal costs.[2]

However, limitations cited for The Michigan Model's results include that the state of Michigan enacted malpractice reform with caps on noneconomic damages, a six-month mandatory pre-suit notice period[3] and certain expert witness requirements that resulted in an overall reduction in malpractice claims state-wide during the UMHS study period. In addition, UMHS is a well-resourced, closed health system that employs its physicians and owns its own captive insurance company – giving it a degree of control over its providers and liability program operations that many healthcare organizations do not have.

CRPs: Successes and challenges

Two different types of CRPs have evolved. One, an early settlement model, such as The Michigan Model, and another, a limited reimbursement model, which is much more limited in scope, with payouts not exceeding a modest amount such as $30,000 to cover out-of-pocket expenses, daily loss of time and sometimes write-off of medical bills. With the limited reimbursement model, patients do not waive their right to sue, as they do with early settlement.[4]

While most, if not all healthcare organizations have implemented disclosure communication following medical error, there are few published reports about organizations that have implemented either type of resolution programs or the effects of the programs on malpractice costs. An exception is a Colorado malpractice insurance company, COPIC, and its limited reimbursement program called the 3Rs program, **R**ecognize unanticipated events, **R**espond soon after the event occurs, and **R**esolve any related issues. After the first five years in existence, COPIC's 3Rs program reportedly had a 50% drop in malpractice claims against its insured physicians and a 23% reduction in claim settlement costs.[5]

One reason for the dearth of published reports of cost savings with CRP programs may be that CRPs take several years to fully implement and then even more time to determine the program's effectiveness in reducing malpractice claims costs. Even UMHS' program took seven to ten years to demonstrate cost savings and/or a reduced rate of cost increases over time. However, programmatic results from early CRP adopters offer some insights into success factors as well as barriers to implementing an effective CRP. Researchers that studied CRPs and their challenges and lessons learned reported the following factors contributing to their success:[6]

- Executive leadership support and a key champion who is passionate about making the CRP work
- Dedicated human, educational and system resources
- CRP design based on the organization's structure, culture and needs

- Knowledge about regulatory compliance such as reporting requirements for the National Practitioner Data Bank and state medical/licensing boards
- Readiness for gradual but transformational culture change that takes place over time in order to reap returns on investment in a CRP

Other investigators of disclosure, apology and offer programs reporting on barriers and strategies for broad implementation shared several insights on CRPs. Although focused on Massachusetts, findings may apply in other states.

The following are some of the key barriers to CRP with possible solutions to overcome them:[7]

BARRIER	POTENTIAL SOLUTION
The charitable immunity law in Massachusetts that limits the tort liability of nonprofit hospitals due to hospitals' limited financial responsibility for medical injuries.	Because the law does not affect settlements, hospitals can offer compensation above the $100,000 cap.
Lack of adequate physician skills with disclosure and communication about adverse events.	Formal training implementation in medical education programs and teaching facilities, as well as by professional societies and malpractice insurers that dedicate continuing medical education credits to disclosure communication.
Lawyers that represent both sides of malpractice claims are likely to resist CRPs because they are viewed as reducing their financial compensation and because attorneys believe injured patients should have legal representation to best serve their interests.	Effective communication to the legal community that legal representation for the patient is actually promoted, not discouraged, and the patient can opt out any time before accepting a settlement. This message should also explain that, along with other benefits, CRPs promote trust in healthcare providers.
When the hospital and the physician are insured by different insurance companies, it is difficult to convince them to work together to expedite resolution of the matter in the patient's interest.	As healthcare systems become increasingly integrated with more physicians being employed, and therefore insured by a common liability program, a united front is more likely.
Reporting requirements for individual physicians to the National Practitioner Data Bank prompt physicians to resist early offer settlements.	Organizations accept system-level responsibility for medical errors deserving of patient compensation instead of payment on behalf of the physician. Although in instances where event investigation reveals clear physician culpability, NPDB reports are made, but the settlement amounts are likely to be much smaller.

Summary

It has been 17 years since the landmark Institute of Medicine (IOM) report on medical errors and the establishment of accreditation standards requiring communication of unanticipated outcomes to patients; yet healthcare providers are still working to adopt common best practices for compensating injured patients fairly and without undue delay when medical care falls below standard. Although time is still needed to measure the return on investment in CRPs, the move to communication and early resolution for preventable medical errors is becoming a central part of contemporary healthcare risk management. Positive results shared by UMHS and COPIC are encouraging and give us sound examples for consideration.

In today's rapidly evolving healthcare environment, the need to demonstrate value in terms of safety and quality has never been more apparent. As payment for healthcare services based on performance increases, better outcomes become the expectation for patients and health insurers. Informed and engaged patients demand transparency as well as restitution when medical errors result in harm. As barriers are overcome, adding offers of fair compensation to disclosure and apology through formal CRPs when care is deemed not reasonable or substandard could ultimately become the norm. In 2016, the Agency for Research and Quality published the CANDOR toolkit (Communication and Optimal Resolution) to assist healthcare organizations in implementing CRPs (http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html). Risk managers are poised to take a leadership role in achieving safe and trusted healthcare and CRPs offer a structure and approach to work to that end.

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