Study finds hospital communication-and-resolution programs do not expand liability risk

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To be more transparent and to promote communication with patients after medical injuries, many hospitals have implemented a new approach

called the communication-and-resolution program (CRP). Through these programs, hospitals openly communicate with patients after adverse events, investigating specifics, providing explanations, and, when necessary, taking responsibility and proactively offering compensation. Medical centers that have adopted this program believe it will help to improve patient safety and that it is the hospital's ethical obligation to disclose medical errors. However, some medical centers are wary that willingly admitting errors could result in increased liability costs. Continuing uncertainty about this issue has continued to be a barrier to the widespread adoption of this program.

A team of researchers at Brigham and Women's Hospital, Baystate Medical Center (BMC), Beth Israel Deaconess Medical Center (BIDMC), Stanford Health Care, and Ariadne Labs, evaluated the liability effects of these communication-and-resolution programs at four Massachusetts hospitals. Their results, published today in a special, "patient safety" edition of *Health Affairs*, found that these programs were associated with improved trends in the rate of new claims and legal defense costs at some of the sites. And they found that the approach did not expand liability risk at any of the sites. The program allowed these organizations to fulfill their ethical obligations to disclose adverse events and promote patient safety without encountering negative liability consequences.

"The CRP approach allows hospitals to 'do the right thing'—be honest about errors, apologize, and compensate patients who are injured by negligence—without adverse financial consequences," said Allen Kachalia, MD, JD, chief quality officer at Brigham and Women's Hospital and first author on the paper.

A communication-and-resolution program known as CARe (Communication, Apology, and Resolution) was implemented at BMC and BIDMC, and at two of each center's community hospitals (Baystate

Franklin Medical Center, Baystate Mary Lane Hospital, Beth Israel Deaconess Hospital-Milton, and Beth Israel Deaconess Hospital-Needham). The team examined the effect of CARe's malpractice claims volume, compensation and legal defense costs, and the time it took to find resolutions. They compared trends in the six years before CARe and then a few years after implementation at each institution. They calculated several quarterly rates for each hospital: new claims, new claims receiving compensation, compensation cost, defense cost, total liability cost, and average compensation cost. A claim was defined as any written request for patient compensation that was brought to the liability insurer, whether initiated by the patient, family, or hospital. This is the first study of its kind that involves two centers in one state and includes comparison groups.

After CARe implementation, the team found there was a significant decrease in the rate of new claims at the implementing community hospitals and academic medical centers, a change that was not seen at hospitals that did not implement CARe. Both academic medical centers experienced a significant decrease for defense costs after CARe implementation. Additionally, there were no significant changes in total liability costs observed nor in the average compensation amount per paid claim at any of the hospitals.

"Our hope is that with these findings, more hospitals will have greater confidence that communicating openly with patients around errors and injury is not likely to create greater liability risk," said Kachalia.

In its special edition, *Health Affairs* also published papers by David Bates, MD, and Gordon Schiff, MD, on patient safety concerns:

Bates' paper, "Two Decades Since To Err Is Human: An Assessment Of Progress And Emerging Priorities In Patient Safety," reviews the Institute of Medicine's "To Err Is Human" report, which initially brought

the problem of patient safety into the public eye 20 years ago. Some of the areas the paper reviews include the evolving identification of patient safety issues, the development and adaptation of effective interventions for hospital-acquired infections, and the emergence of new safety risk areas, including diagnostic error and technology-related concerns.

In Schiff's paper, entitled "A Prescription for Enhancing Electronic Prescribing Safety," he and a team of clinicians, communications safety, and health IT experts outlined six steps and areas of improvement to a safer and easier electronic prescribing system that could lead to fewer errors and better cost-effectiveness.

More information: Kachalia. Effects of A Communication-And-Resolution Program on Hospitals' Malpractice Claims and Costs; *Health Affairs*. DOI: 10.1377/hlthaff.2018.0720

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