PATIENT SAFETY INTITIATIVES AND THE TORT SYSTEM

Medicaid Redesign Team:

Medical Malpractice Reform Work Group

Thursday, October 27, 2011

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"TEMPORAL TRENDS IN RATES OF PATIENT HARM RESULTING FROM MEDICAL CARE" NEJM, NOV 25, 2010

"In December 1999, the Institute of Medicine (IOM) reported that

medical errors cause up to 98,000 deaths and more than 1 million injuries each year in the United States.

In response, accreditation bodies, payers, nonprofit organizations, governments, and hospitals launched major initiatives and invested considerable resources to improve patient safety. Some interventions have been shown to reduce errors… However, many of these interventions have not been evaluated rigorously or implemented reliably on a large scale…"

"Our findings validate concern raised by patient-safety experts in the United States and Europe that harm resulting from medical care remains very common. Though disappointing, the absence of apparent improvement is not entirely surprising…the penetration of evidence-based safety practices has been quite modest…**"**

"…achieving transformational improvements in the safety of health care will require further study of which patient-safety efforts are truly effective across settings and a refocusing of resources, regulation, and improvement initiatives to successfully implement proven interventions.**"**

Landrigan et al, "Temporal Trends in Rates of Patient Harm Resulting from Medical Care," NEJM, Nov 25, 2010.

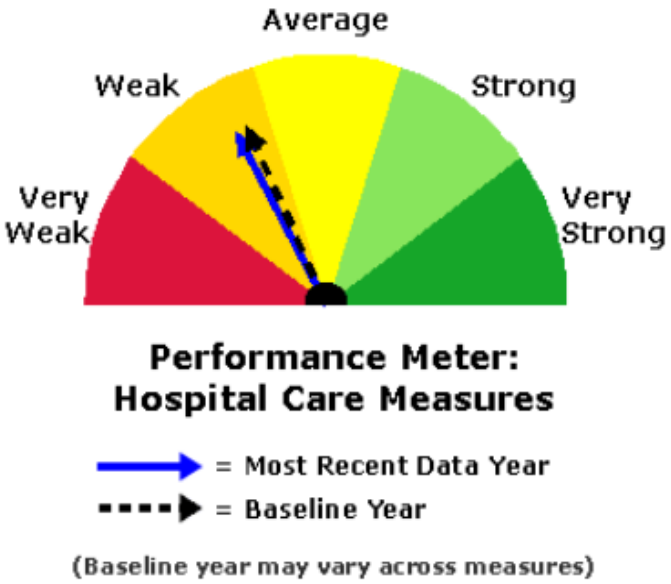
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

The AHRQ compares how well hospitals perform on 31 key quality and patient safety measures. **The AHRQ 2010 hospital "performance meter" for New York as compared to that of all states:***

New York

What Is the Hospital Care Quality Performance Compared to All States?

How Has That Performance Changed?



*Accessed at http://statesnapshots.ahrq.gov/snaps10/settingsofcare.jsp?menuId=12&state=NY&level=5

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
PERFORMANCE OF ALL STATES ACROSS ALL MEASURES IN HOSPITAL CARE 2010

Rank	State	Meter Score for Hospital Care
1	OH	78.12
2	MI	76.09
3	ME	70.69
4	PA	70.59
5	FL	70.31
6	SC	70.31
7	NH	66.67
8	MN	66.13
9	MT	65.62
10	VA	65.62
11	VT	65.38
12	UT	63.79
13	WI	62.9
14	IA	61.29
15	NC	59.38
16	NJ	57.81
17	SD	56.25
18	CT	54.84
19	MA	54.84
20	ID	53.12
21	NE	51.61
22	ND	50
23	RI	48.28
24	DE	46.88
25	IL	46.88
26	CO	41.94
27	MO	41.94
28	AZ	40.32
29	WA	40.32
30	WV	40
31	AR	39.06
32	CA	37.5
33	IN	37.5
34	OR	37.1
35	KS	34.38
36	**NY**	**34.38**
37	MD	32.26
38	OK	32.26
39	GA	31.25
40	TN	31.25
41	WY	28.26
42	KY	28.12
43	HI	22.58
44	NV	22.58
45	TX	19.57
46	AK	17.86
47	AL	17.65
48	MS	11.76
49	DC	9.38
50	LA	5.88
51	NM	3.12

http://statesnapshots.ahrq.gov/snaps10/overall_quality.jsp?menuId=12&state=NY&sCol=speed&sDir=DESC&level=5&region=0&compGroup=N&compRegion=-1

HEALTHGRADES HOSPITAL PATIENT SAFETY RANKINGS

The annual *HealthGrades Patient Safety in American Hospitals Surveys* for both 2010 and 2011 scored **New York's "Overall Average"** for hospital safety to be among the **"Bottom 10 States".*** The rankings were based on risk-adjusted performance on 13 patient safety indicators developed by the U.S. Agency for Healthcare Review and Quality.

HEALTHGRADES®

*http://www.healthgrades.com/business/img/HealthGradesPatientSafetyInAmericanHospitalsStudy2011.pdf (Page 30)

http://www.healthgrades.com/media/DMS/pdf/PatientSafetyInAmericanHospitalsStudy2010.pdf (Page 32)

WSJ.com THE WALL STREET JOURNAL. ONLINE

“Once Seen as Risky, One Group Of Doctors Changes Its Ways

Anesthesiologists Now Offer Model of How to Improve Safety, Lower Premiums”

By JOSEPH T. HALLINAN - Staff Reporter of THE WALL STREET JOURNAL - June 21, 2005

“The rising cost of medical-malpractice insurance has hit many doctors, especially surgeons and obstetricians. But one specialty has largely shielded itself:

Anesthesiologists pay less for malpractice insurance today, in constant dollars, than they did 20 years ago. That's mainly because some anesthesiologists chose a path many doctors in other specialties did not. Rather than pushing for laws that would protect them against patient lawsuits, these anesthesiologists focused on improving patient safety. Their theory: Less harm to patients would mean fewer lawsuits.

Over the past two decades, anesthesiologists have advocated the use of devices that alert doctors to potentially fatal problems in the operating room. They have helped develop computerized mannequins that simulate real-life surgical crises. And they have pressed for procedures that protect unconscious patients from potential carbon-monoxide poisoning.

All this has helped save lives.

Over the past two decades, patient deaths due to anesthesia have declined to one death per 200,000 to 300,000 cases from one for every 5,000 cases, according to studies compiled by the Institute of Medicine, an arm of the National Academies, a leading scientific advisory body.

Malpractice payments involving the nation's 30,000 anesthesiologists are down, too, and **anesthesiologists typically pay some of the smallest malpractice premiums around. That's a huge change from when they were considered among the riskiest doctors to insure**. Nationwide, the average annual premium for anesthesiologists is less than $21,000, according to a survey by the American Society of Anesthesiologists. An obstetrician might pay 10 times that amount, Medical Liability Monitor, an industry newsletter, reports.

http://www.saynotocaps.org/newsarticles/once_seen_as_risky.htm

HEALTHCARE-ACQUIRED INFECTION PREVENTION PROGRAMS: INFECTION RATE AND COST REDUCTIONS

• After adjusting for the range of effectiveness of possible infection control interventions, **the benefits of prevention range from a low of $5.7 billion (20% of infections preventable) to a high of $31.5 billion (70% preventable).**

Centers for Disease Control, *The Direct Medical Costs of Healthcare Associated Infections in the U.S. and the Benefits of Prevention*, March 2009.

• **"**Hand washing is considered vital in health care settings to prevent the spread of potentially-infectious pathogens, like Methicillin-resistant Staphylococcus aureus. **And close attention to such basic hygiene could be a way of reducing the nation's hospital bills by billions of dollars**."

Kevin Sack, "A Hospital Hand-Washing Project to Save Lives and Money," *NY Times,* September 10, 2009.

• Each year central venous catheters cause an estimated 80,000 blood-stream infections and result in up to 28,000 patient deaths in ICUs. The average cost of a catheter-related blood stream infection is $45,000. The main components of the Michigan Keystone ICU Patient Safety Program implemented at 108 ICUs included measures like hand washing, removal of unnecessary catheters and using full-barrier precautions during the insertion of central venous catheters. **The program resulted in up to a 66% reduction in catheter-related bloodstream infection rates.**

Pronovost et al, "An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU," *New England Journal of Medicine*, December 28, 2006.

RESULTS OF OBSTETRICS SAFETY PROGRAMS IN OTHER U.S. HOSPITALS

Hospital Corporation of America:

"Comprehensive redesign of patient safety processes" in obstetrics more than halved the number of obstetrical claims against HCA facilities and resulted in

"**nearly a 5-fold reduction in the cost of claims**."

"In this large health system, with nearly 200 hospitals nationwide, obstetric malpractice claims currently rank behind `accidents on hospital grounds' in terms of litigation loss and cost."

Clark et al, "Improved outcomes, fewer cesarean deliveries, and reduced litigation: results of a new paradigm in patient safety," *American Journal of Obstetrics and Gynecology*, August 2008.

Catholic Healthcare Partners (Cincinnati):

"Comprehensive perinatal patient safety program" at 16 perinatal centers resulted in a 65% decline from 2003 to 2008 in obstetrical occurrences (a "birth-related event or injury that may lead to a claim"),

the average cost per obstetrical claim fell from $1 million to less than $500,000 and the number of new claims reported decreased by 48%.

Simpson et al, "A comprehensive Perinatal Patient Safety Program to Reduce Preventable Adverse Outcomes and Costs of Liability Claims," *The Joint Commission Journal on Quality and Patient Safety*," November 2009.

OBJECTIVE ANALYSIS. EFFECTIVE SOLUTIONS.

“Better Patient Safety Linked to Fewer Medical Malpractice Claims in California”

FOR RELEASE
April 15, 2010

“**Reducing the number of preventable patient injuries in California hospitals from 2001 to 2005 was associated with a corresponding drop in malpractice claims against physicians, according to a study issued today by the RAND Corporation**.

“Researchers studied both medical malpractice claims and adverse events such as post-surgical infections across California counties and found that changes in the frequency of adverse events were strongly correlated with corresponding changes in the volume of medical malpractice claims.

“‘These findings suggest that putting a greater focus on improving safety performance in health care settings could benefit medical providers as well as patients,’ said Michael Greenberg, the study's lead author and a behavioral scientist with RAND, a nonprofit research organization.

“The link between safety performance among health care providers and malpractice suits has been of central interest to policymakers in the ongoing debate over health care reform. **The RAND study is the first to demonstrate a link between improving performance on 20 well-established indicators of medical safety outcomes and lower medical malpractice claims**.**”**

…

Source: Rand Corporation press release, April 15, 2010

New York Presbyterian Hospital

"Effect of a comprehensive obstetric patient safety program on compensation payments and sentinel events"

Amos Grunebaum, MD; Frank Chervenak, MD; Daniel Skupski, MD

Improving patient safety has become an important goal for hospitals, physicians, patients, and insurers. Implementing patient safety measures and promoting an organized culture of safety, including the use of highly specialized protocols, has been shown to decrease adverse outcomes; however, it is less clear whether decreasing adverse outcomes also reduces compensation payments and sentinel events.

Our objective is to describe comprehensive changes to our obstetric patient safety program and to report their impact on actual spent compensation payments (sum of indemnity and expenses paid) and sentinel events.

Materials and Methods

New York Presbyterian Hospital-Weill Cornell Medical Center is a tertiary academic referral center with a level 3 neonatal intensive care unit and serves as a New York State regional perinatal center. The labor and delivery unit performs about 5200 deliveries per year of which voluntary attending physicians manage approximately 25%, and 75% are managed by full-time faculty. The New York Weill Cornell Investigation
Research Board approved this report as exempt research.

Patient safety program

In 2002, we began to implement in a step-wise fashion a comprehensive and ongoing patient safety program. The date of implementation is included for each step.

Consultant Review (2002)

In 2002, as part of an obstetric initiative by our insurance carrier (MCIC Vermont, Inc., Burlington, VT), **2 independent consultants reviewed our department and assessed our institution's obstetric service**. **This review resulted in specific recommendations and provided a general outline for making changes and improvements in patient safety. Building on these findings, we implemented a comprehensive obstetric patient safety program.**

American Journal of Obstetrics & Gynecology, February 2011.

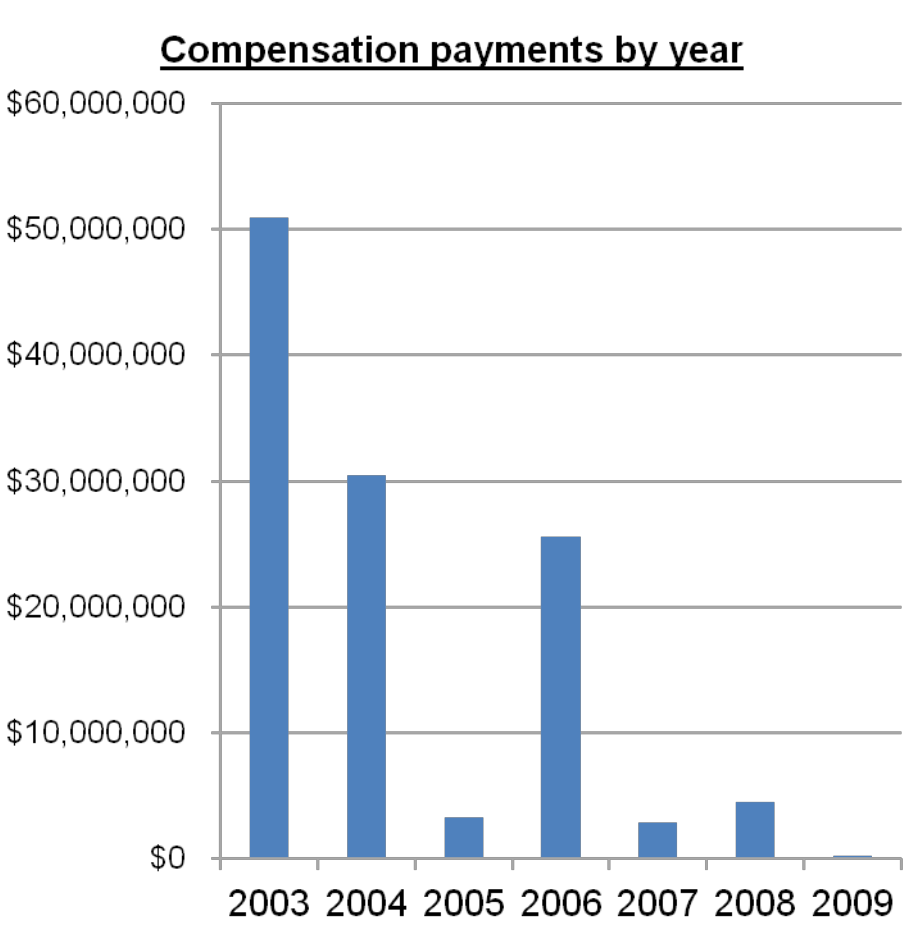
NEW YORK PREBYTERIAN HOPSITAL OBSTETRIC PATIENT SAFETY PROGRAM

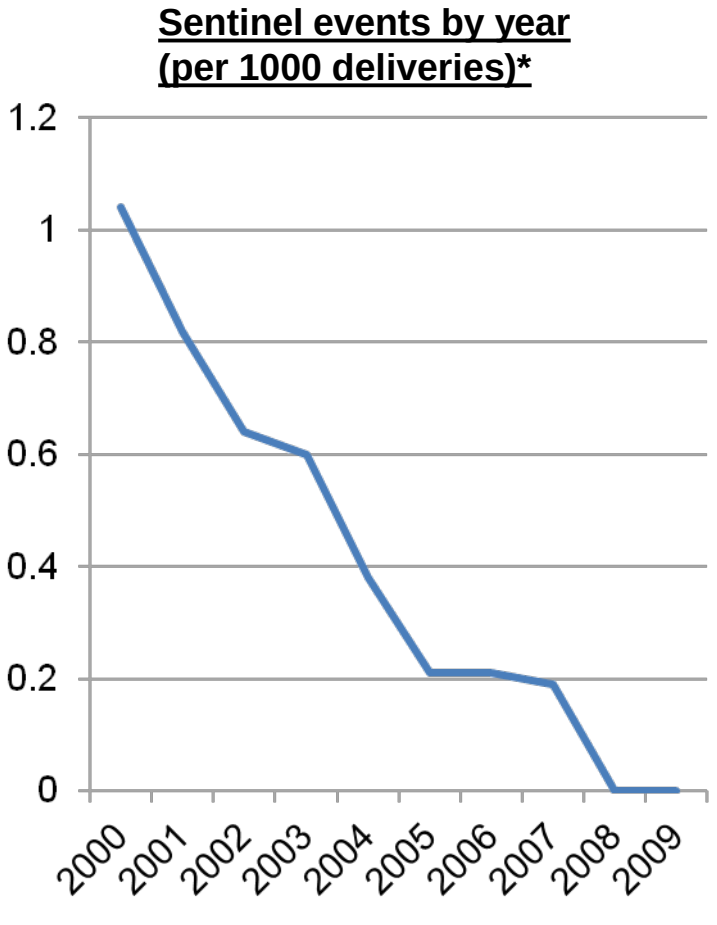
Key elements:

- Interdisciplinary team training, focusing on better communication
- Obstetric emergency drills
- Electronic medical record charting for all patients in labor and delivery
- Clear chain of communication, from nurse up to chairman of the department
- Standardized oxytocin labor induction and stimulation protocol and addition of an oxytocin initiation checklist and color-coding of magnesium sulfate and oxytocin solution labels
- Employment of an obstetric patient safety nurse who is involved in training, implementation of protocol changes, obstetric emergency drills, etc.
- Addition of three new physician's assistants and a laborist on nights and weekends
- Electronic fetal monitor interpretation certification required of staff
- Routine thromboembolism prophylaxis for all cesarean deliveries
- Retrospective review of obstetric compensation payments and new and ongoing lawsuits

NEW YORK PRESBYTERIAN HOPSITAL OBSTETRIC PATIENT SAFETY PROGRAM "RESULTS"

"The 2009 compensation payment total constituted a 99.1% drop from the average 2003-2006 payments (from $27,591,610 to $250,000)."





Grunebaum et al, Effect of a comprehensive patient safety program on compensation payments and sentinel events," *American Journal of Obstetrics & Gynecology ,* Feb 2011 et al.

*A sentinel event is "an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof."

NEW YORK PRESBYTERIAN HOSPITAL OBSTETRIC PATIENT SAFETY PROGRAM "COMMENT"*

"Our results show that implementing a comprehensive obstetric safety program not only decreases severe adverse outcomes but can also have an immediate impact on compensation payments."

"The $25,041,475 yearly savings in compensation payments for the last 3 years alone dwarf the incremental cost of the patient safety program…"

"Making significant changes on a labor and delivery unit including … implementation of a standardized oxytocin protocol, electronic charting, team training, and improving situational awareness through a central communication system, should be considered by all obstetric services."

*Grunebaum et al, Effect of a comprehensive patient safety program on compensation payments and sentinel events," *American Journal of Obstetrics & Gynecology ,* Feb 2011 et al.

CONTROLLED RISK INSURANCE COMPANY (CRICO)

"As the patient safety and medical professional liability provider owned by and serving the Harvard medical community for more than 30 years, CRICO is dedicated to providing industry-leading insurance coverage, expert legal and claims services, and **pioneering patient safety methodologies**…"

"CRICO is an internationally renowned leader in evidence-based risk management, proudly serving 21 hospitals, more than 12,000 physicians (including residents and fellows), and 207 other health care organizations."

http://www.rmf.harvard.edu/company/about-us.aspx

"CRICO/RMF Strategies…uses medical malpractice data to help hospitals across the nation dramatically reduce medical errors and minimize financial loss…"

"CRICO/RMF Strategies offers proven methodologies and data-driven insights that reveal hidden areas of risk and deliver actionable intelligence to drive fundamental change that transforms the safety of patient care…"

http://www.marketwire.com/press-release/crico-rmf-strategies-convenes-emergency-medicine-leadership-council address-crisis-americas-1514740.htm

CRICO/RMF: "PSAG CORE CURRICULUM FOR PATIENT SAFETY"

***Excerpts from Module 1: Introduction to Patient Safety*:**

"In the time it will take you to complete this module, 80 patients in the American health care system will be injured, and 10 will die, because of preventable medical errors…"

"This is a serious public health problem..."**"**

"…Although the individual professional is the final pathway by which these errors happen, **errors designed into our systems are waiting to be made, if not by you, then by the next doctor or nurse**."

"What would it look like if leaders were to direct attention to the issue of medical error? … Reported error rates would go up for awhile because we currently underreport errors and near misses by a factor of 10.**"**

"…When errors occur, we would learn and prevent, rather than blame and hide... **Our patients would be injured less often, and health care costs would go down considerably."**

http://www.rmf.harvard.edu/education-interventions/materials-for-instructors/patient-safety/index.aspx#essay

CRICO/RMF ON FRIVOLOUS LAWSUITS AND PATIENT SAFETY

"NOT A FRIVOLOUS MATTER"

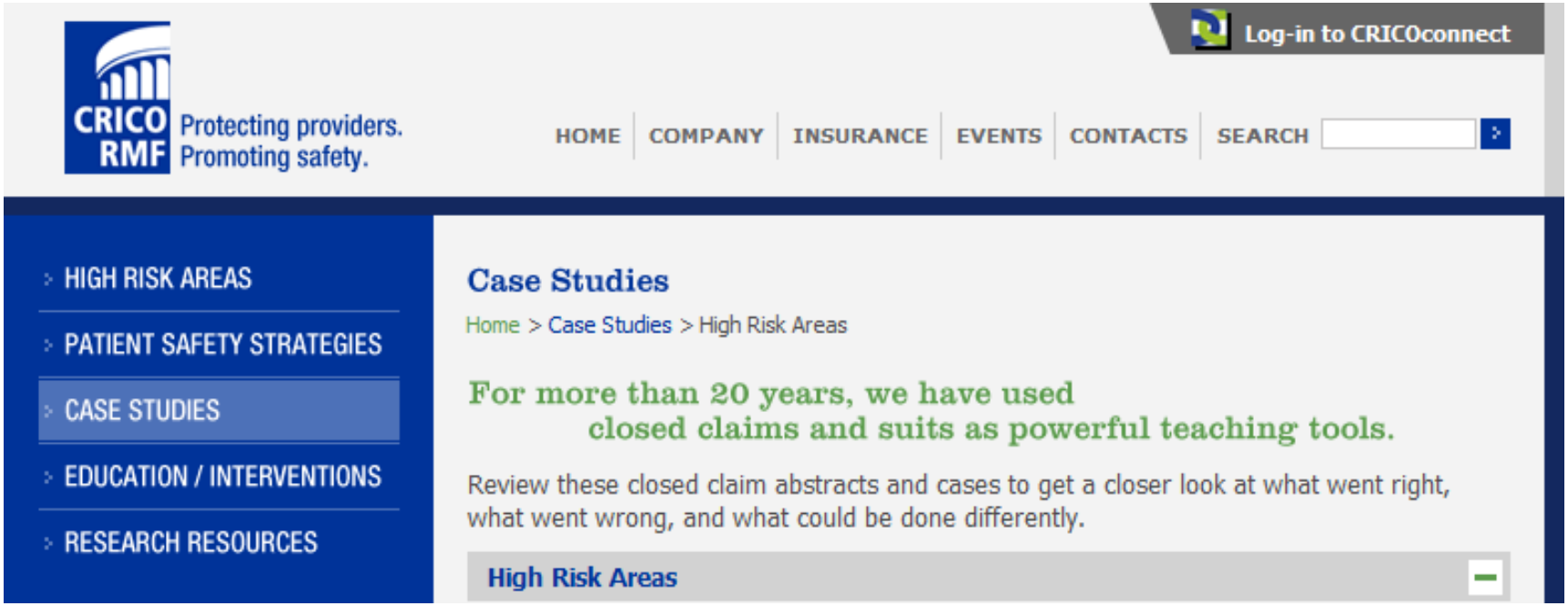
by Jock Hoffman, Patient Safety Education Program Director, CRICO/RMF
January 2011

"…`**frivolous' malpractice suits are less common than the politicians espousing them**. Plaintiffs whose claims lack the fundamental legal components are challenged to find an attorney willing to devote time and out-of-pocket resources, unlikely to find a tolerant court, and even less likely to receive compensation…"

"Rather than dwell on the frivolous bogeyman, politicians, and health care providers will likely be more successful at reducing patient injuries, costs, and lawsuits by studying the underlying causes of the malpractice cases that reflect suboptimal care and present opportunities to repair flaws in the health care delivery system. Seriously."

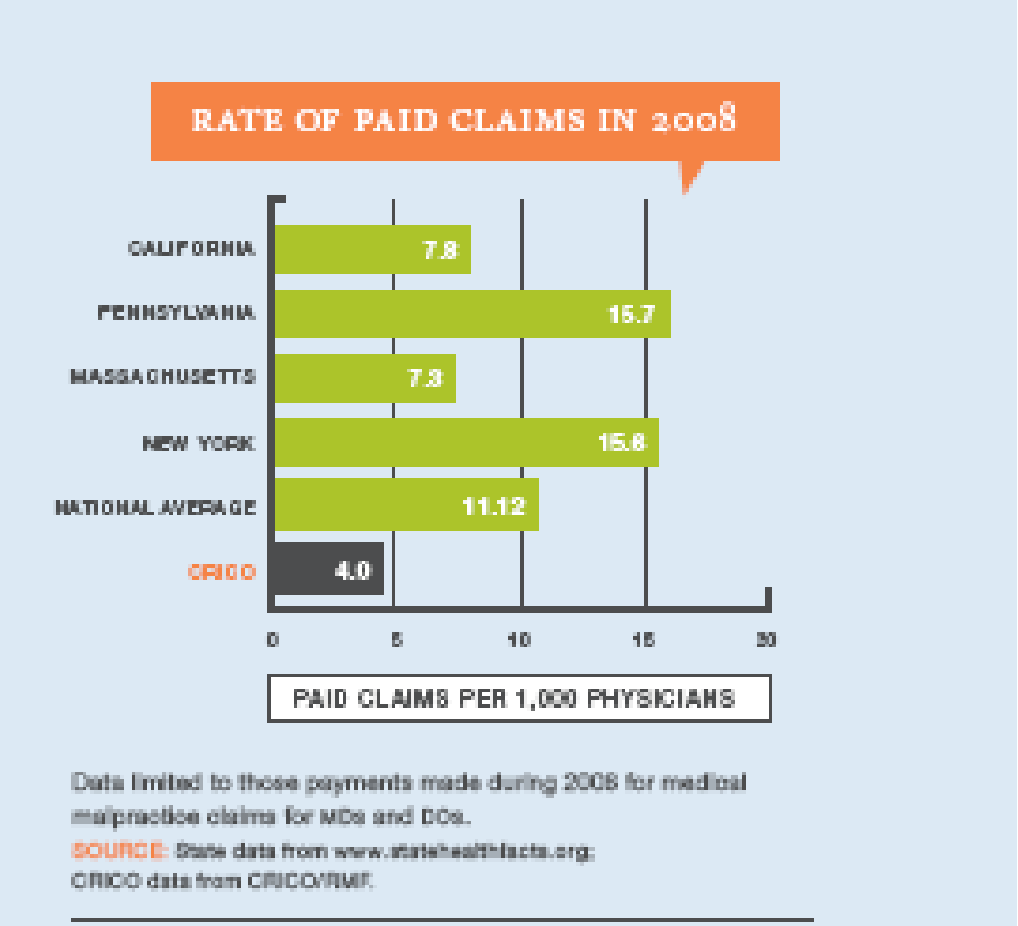
http://www.rmf.harvard.edu/education- interventions/sps/issues/SPS-1-2011.html

CRICO/RMF ON THE USE OF CASE STUDIES



http://www.rmf.harvard.edu/case-studies/index.aspx

CRICO/RMF 2009: The Year in Review

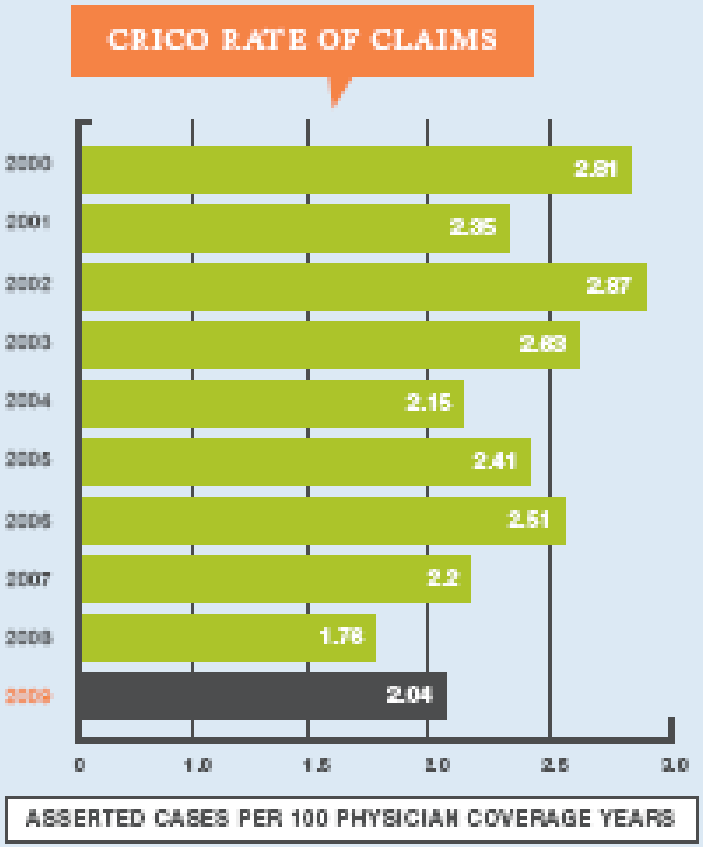


http://www.rmf.harvard.edu/files/documents/Focus_2009_Year_Review.pdf

The Kaiser Family Foundation, www.statehealthfacts.org.

SOURCES: American Medical Association, Physicians Professional Data, copyright 2009; Special Data Request

SOURCES: Kaiser Family Foundation analysis of data from the National Practitioner Data Bank (NPDB), Public Use Data File (NPDB2905.POR), U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Practitioner Data Banks; accessed 9/3/09.



http://www.rmf.harvard.edu/files/documents/Focus_2009_Year_Review.pdf

ANESTHESIA PATIENT SAFETY FOUNDATION *NEWSLETTER*
THE OFFICIAL JOURNAL OF THE ANESTHESIA PATIENT SAFETY FOUNDATION, Spring 2007

"Malpractice Insurance Carrier Provides Premium Incentive for Simulation-Based Training and Believes It Has Made a Difference"

by Jack McCarthy and Jeffrey B. Cooper, PhD

In 2001, the Consolidated Risk Insurance Company (CRICO)…**introduced** an **incentive for anesthesiologists** who received training in Crisis Resource Management at the Center for Medical Simulation (CMS) in Cambridge, MA. **CRICO believes that this has made a difference and has since tripled the incentive, which is now 19%.**

Based on its perceived success in anesthesia, CRICO has created a similar incentive program in OB/GYN... **Starting three years ago, a 10% incentive was implemented for OB/GYN physicians** who participated in either a simulation-based training program or an organization wide teamwork program and several other educational requirements. Although there is not yet sufficient experience with that program, **CRICO claims have been trending lower at those institutions with active team training or simulation training**. **CRICO/RMF is now planning additional incentive programs in other specialties …**

http://www.apsf.org/newsletters/html/2007/spring/17_malpractice.htm

RISK RETENTION REPORTER, JUNE 2007

"Risk Retention Group Offers Incentives to Reduce Claims Frequency"

Excerpts from a *Risk Retention Reporter* interview with Jack McCarthy, President of Risk Management Foundation of the Harvard Medical Institutions, the administrative organization for Controlled Risk Insurance Co. of Vermont (A Risk Retention Group):

"RRR: What results have you seen from the [OB] discount program?"

"McCarthy: ... **Our preliminary results at BIDMC** [Beth Israel Deaconess Medical Center], the location for the first team training, **are very encouraging**. In the three years prior to team training, BI had 7 OB claims and suits with 5 (71%) being high severity. In the three years post training, claims and suits dropped to 2 and high severity to 1. Another measure, **the Adverse Outcomes Index …shows a 55% drop over the same period of study. This would tend to validate the claims experience**."

"RRR: What's next?"

"McCarthy: Office practice evaluations (OPE) are done by CRICO/RMF staff. These OPEs focus on test result handling, referral management, and quality of office records. We are piloting a discount program and providers will receive a 10% discount for a score of 85% or better on a range of evaluation factors... **Our assessment is that positive incentives can accelerate adoption of patient safety and risk management programs**. These incentives have had a positive payback for our program in the short run and we are interested in adding specialties and continuing to measure the impact on premium and bottom line results.**"**

http://www.rmf.harvard.edu/files/documents/RRR_mcarthy_2006-07.pdf

WEIL-CORNELL MEDICAL COLLEGE PATIENT SAFETY VIDEO