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## *Member Briefing:*

# Massachusetts Alliance for Communication and Resolution Following Medical Injury (MACRMI)

Monday, December 3, 2012  
1:00-3:00 PM

# Agenda

## 1. Welcome

Pat Noga, PhD, RN, VP Clinical Affairs  
Anuj Goel, Esq, VP Legal & Regulatory Affairs  
Massachusetts Hospital Association

## 2. Transforming the Medical Liability System in Massachusetts

Alan Woodward, MD  
Massachusetts Medical Society

## 3. Medical Liability Reform: Moving to Implementation in Massachusetts

Kenneth Sands, MD  
Beth Israel Deaconess Medical Center

# TRANSFORMING THE MEDICAL LIABILITY SYSTEM IN MASSACHUSETTS

Massachusetts Hospital Association

December 3, 2012

Alan Woodward, MD

Massachusetts Medical Society



# Transformation Process

- Failings of current system
- Options for reform - Tort?
- Disclosure, Apology and Offer
- Advantages and Evidence
- AHRQ Planning Grant
- Roadmap for State
- Alliance for Implementation and Pilots
- Enabling Legislation - Reporting

# What is Wrong with the Status Quo?

## Impact on patients

- Baseline suspicion: Compromises the physician-patient relationship
- Unfair: A small minority of avoidably injured patients receive compensation
- Slow: Average time to award is more than 5 years
- Inequitable and inconsistent: Awards highly variable (“jackpot justice”)
- Inefficient and expensive: Patients receive less than 30% of premium dollars paid
- “Wall of Silence” between patients and physicians – no apology
- Compromises access to care
- Impedes patient safety improvement

# What is Wrong With the Status Quo?

## Impact on physicians

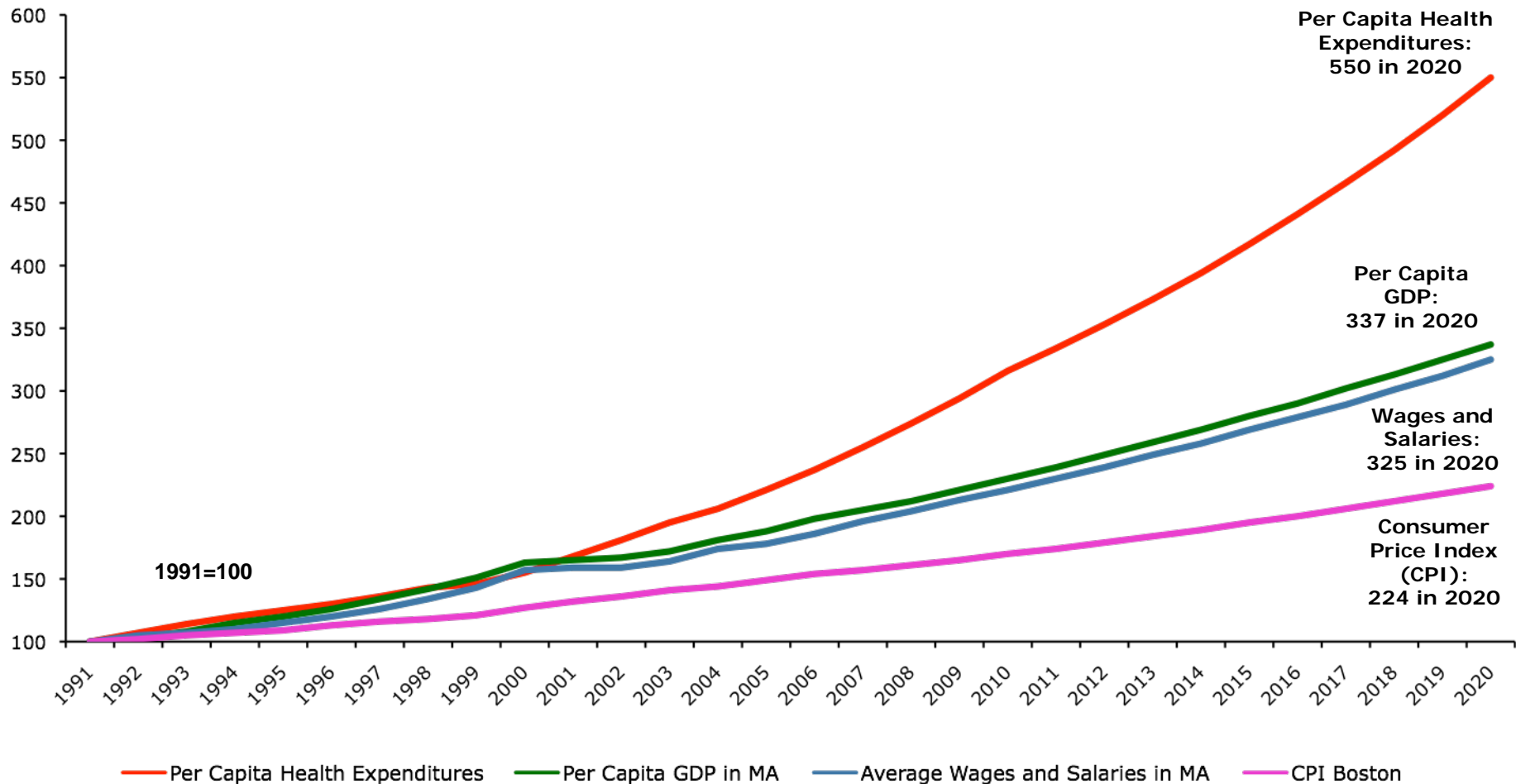
- Premiums are burdensome / unaffordable
- View patients as potential litigants
- Stress of “never being wrong”
- Avoid high risk procedures / patients
- Leaving practice or retiring early
- Negative health impacts
- Don't trust the justice system and “always lose”
- Practice defensive medicine

# What is Wrong With the Status Quo?

## Impact on Health Care System

- Thwarts patient safety improvement
- Undermines the practice environment
- Compromises size, distribution and well-being of health care workforce
- Compromises access to care
- Drives over-utilization - defensive medicine
- Drives up overall cost of health care
- Increases the number of uninsured / underinsured

# Rising Costs

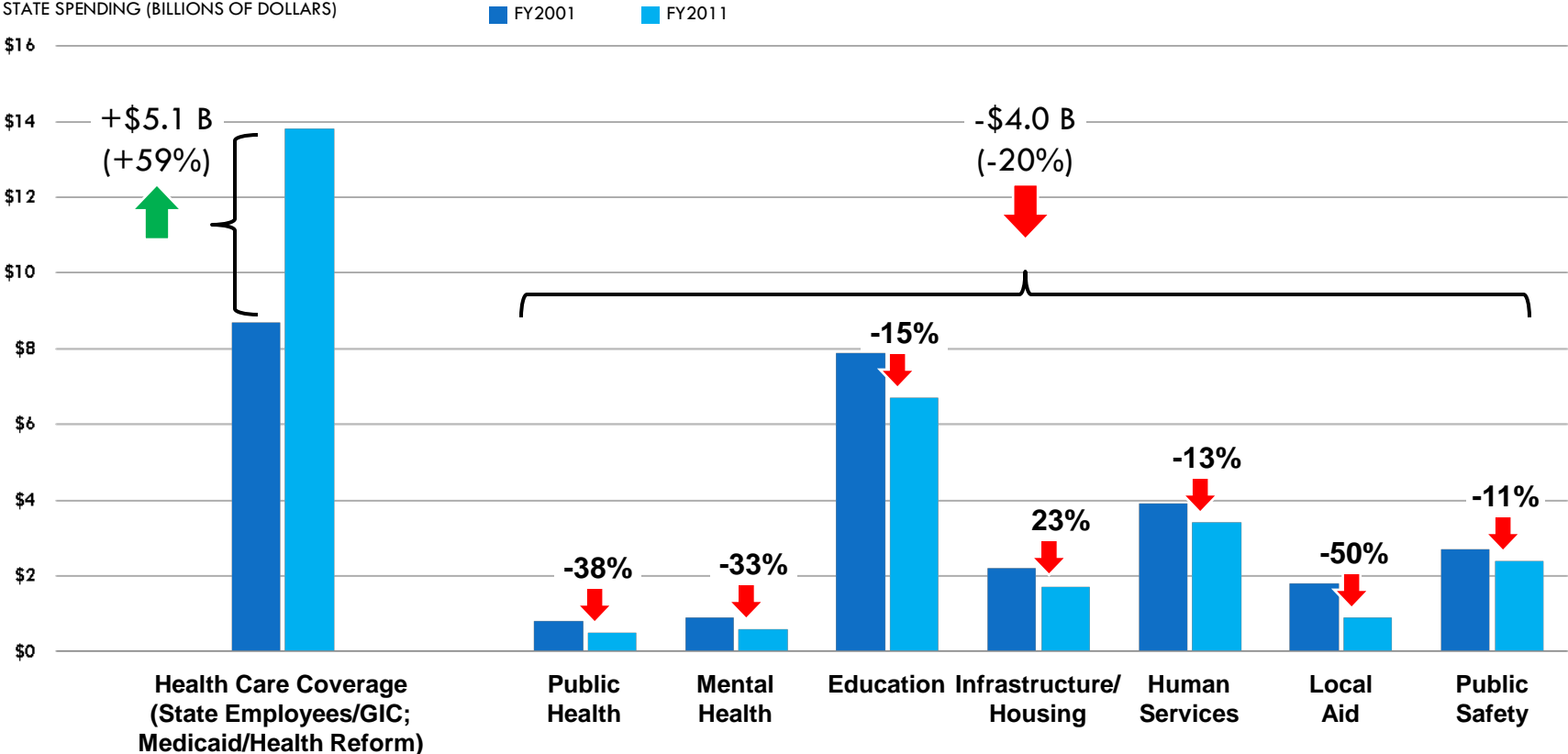


Source: Mass. Dept. of Health Care Finance and Policy



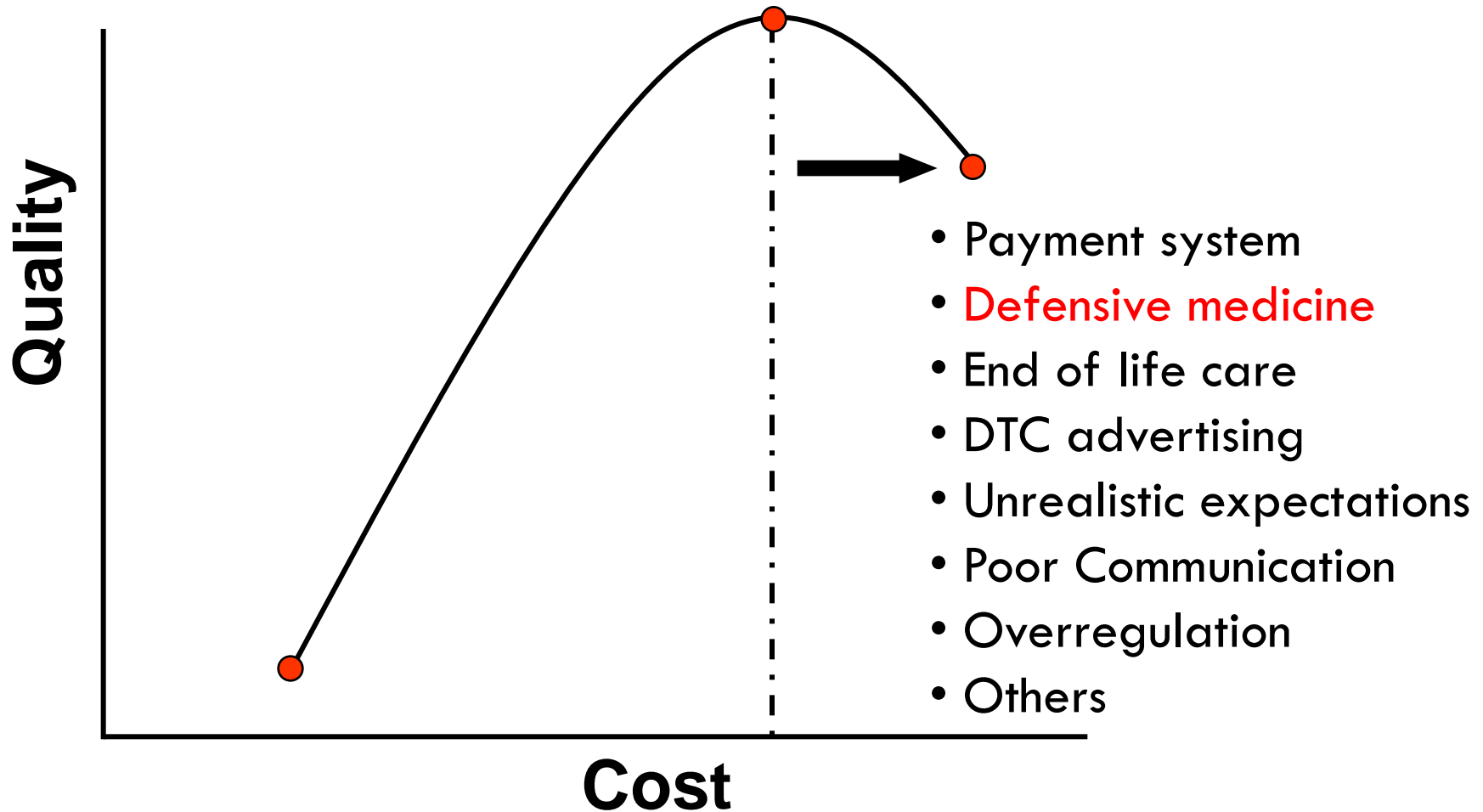
# Increasing Costs of Health Care Squeeze Out Other Public Spending Priorities

MASSACHUSETTS STATE BUDGET, FY2001 VS. FY2011



SOURCE: Massachusetts Budget and Policy Center [Budget Browser](#).

# Overuse: Resource Drivers



# Estimates of Defensive Medicine

- Studdert (2005): 93% of physicians practice defensive medicine
- AAOS 2010 concurrent study: 72 OS care >2000 Pts revealed 20% of tests and 35% of costs DM
  - 2012 survey 96% practice DM → 24% of costs
- Tillinghast (2000): \$70 billion annually in U.S.; \$1.5 billion in Mass. (\$253 per person)
- MMS (2008) Survey – pervasive, 18-28% tests – 13% admissions - \$1.4 billion quantified
- Multiple studies - range from 2% to 35% (10-15%)

# The result . . .

The current liability system is unduly onerous for the patient and provider, and undermines the integrity, safety and efficiency of our entire health care system.

“For compensation, deterrence, corrective justice, efficiency and collateral effects, the system gets low or failing grades.”

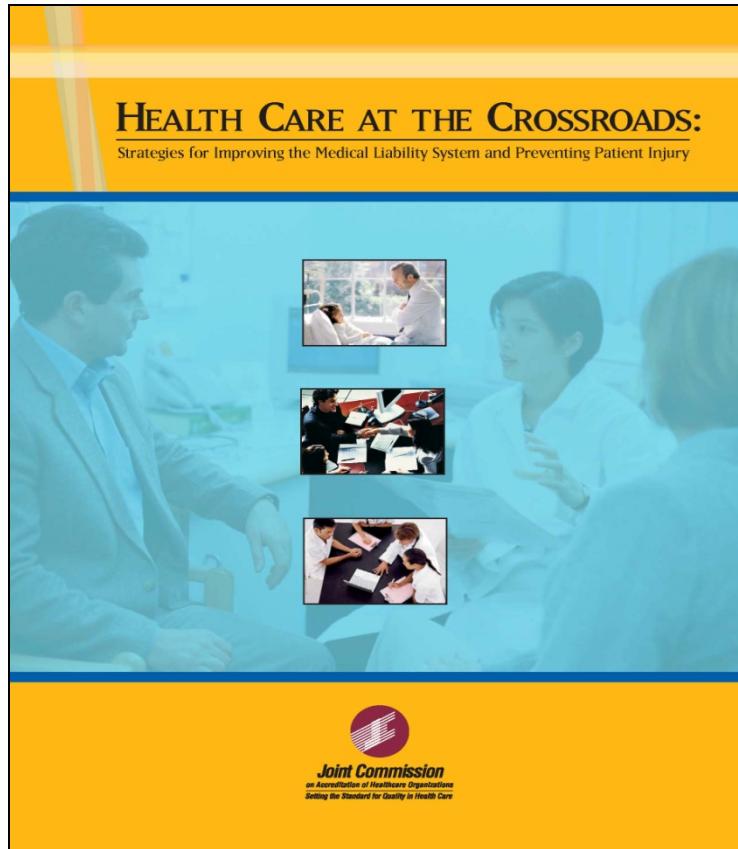
- Michelle Mello, Harvard School of Public Health

**The status quo is unaffordable,**  
**unsustainable and undesirable.**

# Medical Liability Reform

- Tort system
  - Difficult to reform
  - Last resort
- A fundamentally different system
  - Fair, efficient, reliable, just and accountable
  - Supports patient safety improvement
  - Reduces the fear driving defensive medicine

# DAO Components



- Baseline culture of safety
  - Root-cause analysis and safety improvement
- Full disclosure
- Apology when appropriate
- Injury compensation
  - Timely and fair
- Alternative dispute resolution
- Tort is the last resort

# A Fundamental Transformation

Reactive	➔	Proactive
Adversarial	➔	Advocacy
Culture of secrecy	➔	Full disclosure / transparency
Denial	➔	Apology (healing)
Individual blame	➔	System repair
Patient/MD isolation	➔	Supportive assistance
Fear	➔	Trust
Defensive medicine	➔	Evidence-based medicine

# University of Michigan: Impacts

- Started in 2001 (262 claims and > 300 open cases)
- By 2007, only 73 new claims and < 80 open cases
- Average case resolution time down from 20 months to 8 months
- Transaction expenses reduced \$48k to < \$20k/case
- By 2002, stopped buying reinsurance
- By 2010, reduced reserves \$72M to \$19M, funding patient safety initiatives
- Court cases reduced more than 90% (1-2/yr)
- Premiums for unlimited coverage are significantly lower
- Culture change - fear factor reduced - don't teach DM
- Incident reporting - increased many fold



# Univ. of Michigan: Faculty Response

- 87% said the threat of litigation adversely impacted the satisfaction they derived from practice
- 98% recognized, and approved of, new approach
- 55% said the new approach was a “significant factor” in their decision to stay at Univ. of Michigan
- Has become a positive physician recruitment tool

# Univ. of Michigan: Plaintiff Bar Response

- 100% rated Univ. Michigan “the best” and “among the best” health systems for transparency
- 90% recognized a change since 2001
- 86% said transparency allowed them to make better decisions about claims to pursue
  - 57% acknowledged they had turned down cases they otherwise would have pursued
- 81% said costs were less
- 71% said they had settled cases for less than if they had litigated

# Signs of Progress/Change

- **National:** VA, Univ. of Michigan, Stanford and multiple other closed systems - Joint Commission, Sorry Works, RWJ
- **Massachusetts:** Dana Farber, CRICO (RMF), MGH pilot, B&W (MITSS), Reliant, Coverys, BIDMC and Baystate – MMS (committed to DAO)
- Evidence was accumulating and forces aligning for change as health reform progressed - cost focus
- AHRQ Grants announced

# Planning Grant for Transformation

## Sponsorship:

- 1 Year planning grant
- \$300 K
- Agency for Healthcare Research and Quality (AHRQ)
- Medical Liability & Patient Safety Demonstration Project program

## Project Team:

**BIDMC:** Kenneth Sands, MD (PI)  
Sigall Bell, MD  
Peter Smulowitz, MD  
Anjali Duva

**MMS:** Alan Woodward, MD  
Elaine Kirshenbaum, MPH  
Charles T. Alagero, JD  
Liz Rover Bailey, JD  
Robin DaSilva, MPH  
Therese Fitzgerald, PhD

**HSPH:** Michelle Mello, JD, PhD

**U. Michigan:** Rick Boothman, JD

# Project Goals

- Identify barriers to implementation of a DA&O model patient safety initiative in Massachusetts
- Develop strategies for overcoming barriers
- Design a Roadmap to reform medical liability and improve patient safety based on study findings
- Examine the degree to which the proposed plan for Massachusetts has applicability for other states.

# Methodological Approach

- Key informant interview study of 27 knowledgeable individuals from all leading stakeholder constituencies in Massachusetts
- Semi-structured in-person interviews of 45-60 minutes, 2 physician interviewers (one exception)
- Interview transcripts excerpted, coded by theme and analyzed using standard content analysis methods
- Strategies evaluated by frequency mentioned, feasibility, importance and time frame
- Road Map drafted and circulated back to interviewees then presented



# Constituencies Sampled by Interviews

- Provider Organizations
  - Academic Hospital
  - Non-academic hospital
  - Physician Practice Groups
- Physician community
  - Academic
  - Non-academic
  - Primary care
  - Subspecialty
- Insurers
  - Health Insurer
  - Malpractice Insurer (captive model)
  - Malpractice Insurer (commercial model)
- Legal
  - Plaintiff's Bar
  - Defense Bar
- Public Entities
  - Massachusetts Legislature
  - Department of Public Health
  - Board of Registration in Medicine
  - Administration, Commonwealth of Mass
- Advocacy Groups (Several)
- Patient Safety Experts

# Barriers to DA&O Model Implementation

Barrier*	# of Respondents
Charitable immunity law	22
Physician discomfort with disclosure and apology	21
Attorneys' interest in maintaining the status quo	20
Coordination across insurers	20
NPDB or state reporting requirements	19
Concern about increased liability risk	16
Forces of inertia	13
Fairness to patients	12
May not work in other settings	11
Insufficient evidence	8
Supporting legislation	8
Accountability for the process	5

\* Other barriers, not listed, were mentioned by <4 respondents



# Strategies Suggested to Overcome Barriers (Sample)

- Charitable Immunity: *Promote Voluntary waiver-by-settlement*
- Clinician Discomfort: *Education and Training*
- Attorney Incentive to Maintain Status Quo: *Promote universal benefits of streamlined process and continued access to legal representation*
- Need for Insurer Collaboration: *Convene insurer forum to proactively address a model*

# Summary

- Overall perception of DA&O model very favorable
  - Positive effects on patient safety frequently noted
  - No alternative viewed more favorably
- Objections raised were primarily barriers to implementation (e.g., difficulty achieving culture change)
- Most suggested strategies to overcome barriers are feasible
- Other stakeholders are highly interested

# Roadmap: Key Points

- Education - programs for all involved parties
- Leadership - from all key constituencies
- Model Guidelines - support consistency
- Collaborative Working Groups - key issues
- Enabling Legislation - to create a supportive environment
- Data Collection and Dissemination

# Initial Implementation Steps

- Disseminate the Roadmap / Media Campaign
- Developing an Alliance for Change (MACRMI)
- Funding – CRICO, Baystate, Coverys - BCBS HPHC TAHP, MMS & Reliant - AHRQ and others in the future
- Engage Key Constituencies and Educate Members
- Establishing Education Resource and Data Center
- Pilot Program in Massachusetts, in a variety of settings
  - Captive vs. commercial insurance
  - Large vs. small hospitals
  - Employed physician vs. independent
  - Pass Enabling Legislation: Resolution period - Sharing records
    - Apology protection - Disclosure

# MACRMI

Massachusetts Alliance for Communication and Resolution following Medical Injury

- BIDMC System - Baystate System
- MMS - Education / Guidelines / Forums
- MHA - Education / Guidelines
- MCPME - Education / Resource Center
- BORM - Reporting / Dissemination
- MITSS - Patient Education / Advocacy
- HSPH - Assessment
- UM - Policies / Workbook / Coaching

# MACRMI and CARE



**CARE** stands for **Communication, Apology and Resolution**; it is **MACRMI's** preferred way to reference the **Disclosure, Apology and Offer** process.

# MACRMI.info

## MACRMI's Website Content

- News and information
- Sections for patients and providers
- Sample guidelines, policies
- Research and articles
- DA&O data (state and national)
- Links to sources of additional assistance and information
- Tools: Q&A forum, public directory, private log-in section, events calendar

Visit us at [www.MACRMI.info](http://www.MACRMI.info)

The screenshot displays the MACRMI website interface. At the top, the MACRMI logo is accompanied by the full name: "Massachusetts Alliance for Communication and Resolution following Medical Injury". Navigation links include "About", "For Patients", "For Providers", "Resource Library & Links", "Blog & News", and "Contact". A search bar and "USER LOGIN" button are also present. The main content area features a "WELCOME" section with placeholder text and a "NEWS & IMPORTANT INFO" section with three news items. Below this is a "TESTIMONIALS" section with four columns of placeholder text and names. At the bottom, a "PLEASE PROVIDE YOUR FEEDBACK" section includes a "CLICK TO EMAIL FEEDBACK" button. The footer contains copyright information and a small logo.

# Pilot Sites

- BIDMC
- BID-Milton
- BID-Needham
- Baystate Medical Center
- Baystate Franklin Medical Center
- Baystate Mary Lane Hospital

Enrollment Start Date: December 1, 2012



# Liability Reform Provisions of CH 224

- Six Month Pre-Litigation Resolution Period \*
- Sharing all Pertinent Medical Records \*
- Apology Protection - unless contradictory \*
- Full Disclosure - significant complication \*
- Pre-judgment Interest Reduction - T+2
- Charitable Immunity Cap Increase - 100k

**Signed into law as part of Chapter 224 - Payment Reform Legislation; Effective November 5, 2012**

**\* MMS, MATA & MBA Consensus**





# Reporting

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- It has been the practice of Liability Insurers in MA to report all payments on behalf of a physician to the NPDB and the BORM.
- We believe the NPDB's definition of a claim may not encompass internally-identified proactive CARE cases, and therefore such payments may not have to be reported, but we will need confirmation from the NPDB.
- The BORM is a member of MACRMI, and we are working with them to resolve state reporting issues, profile information and their definition of a claim. Such changes may require new regulations or legislation.

# Implications Beyond Massachusetts

Massachusetts has unique barriers ...

- Charitable immunity

- Restrictive reporting requirements

... But unique advantages

- Universal coverage

- Payment reform

- New enabling legislation

And many of the identified impediments and solutions are in fact applicable in other states.

# Multiple Benefits

Right and Smart thing to do

- For Patients
- For Patient Safety
- For Providers
- For Hospitals / ACOs
- For Healthcare Access and Affordability



# MEDICAL LIABILITY REFORM: MOVING TO IMPLEMENTATION IN MASSACHUSETTS

Kenneth Sands, MD MPH

Senior Vice President, Health Care Quality

Beth Israel Deaconess Medical Center





# Moving to Implementation:

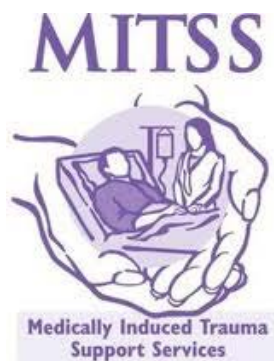


Massachusetts Alliance for Communication and Resolution following Medical Injury

## Massachusetts Alliance for Communication and Resolution following Medical Injury



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# MACRMI and CARE



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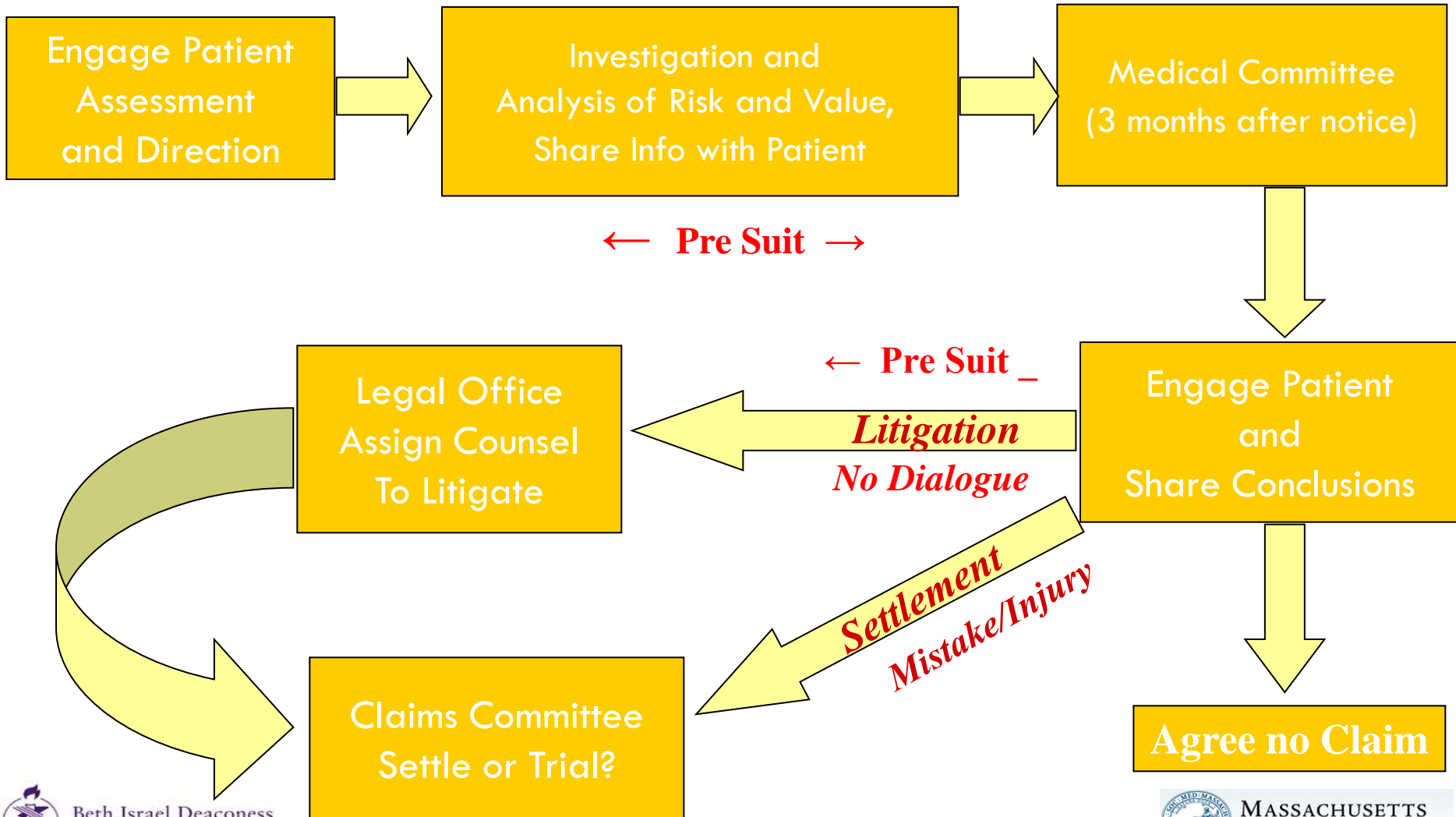


# Principles of CARE

- Compensate patients quickly and fairly when unreasonable medical care caused injury.
- If the care was reasonable or did not adversely affect the clinical outcome, support caregivers and the organization vigorously.
- Reduce patient injuries (and therefore claims) by learning through patients' experiences.

“Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions.” Boothman, et al; *Frontiers of Health Service Management* 28:3; study at the University of Michigan Health System

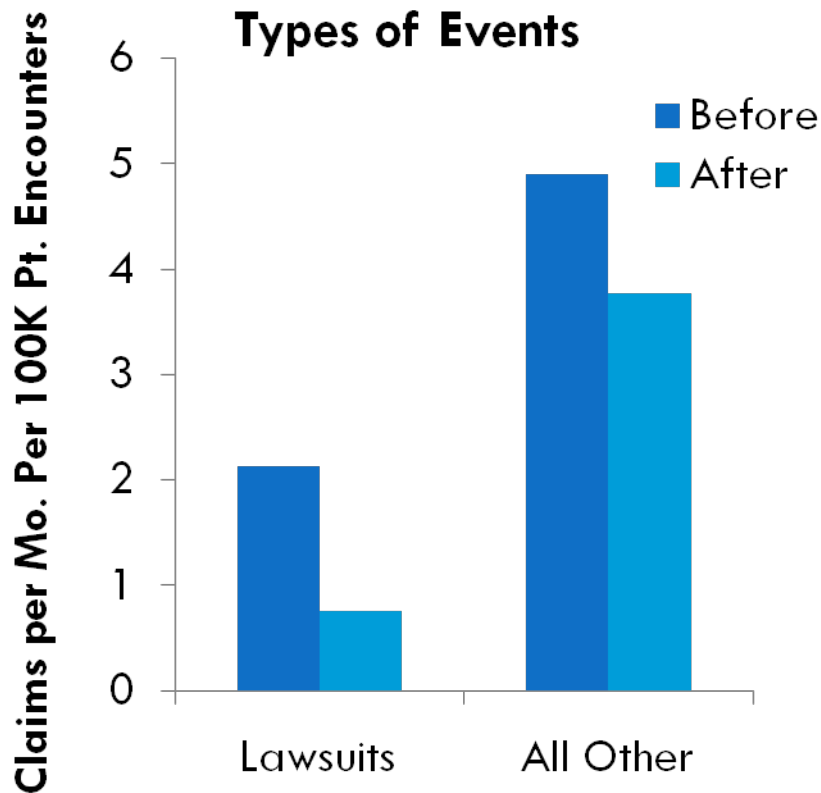
# U. Michigan Model



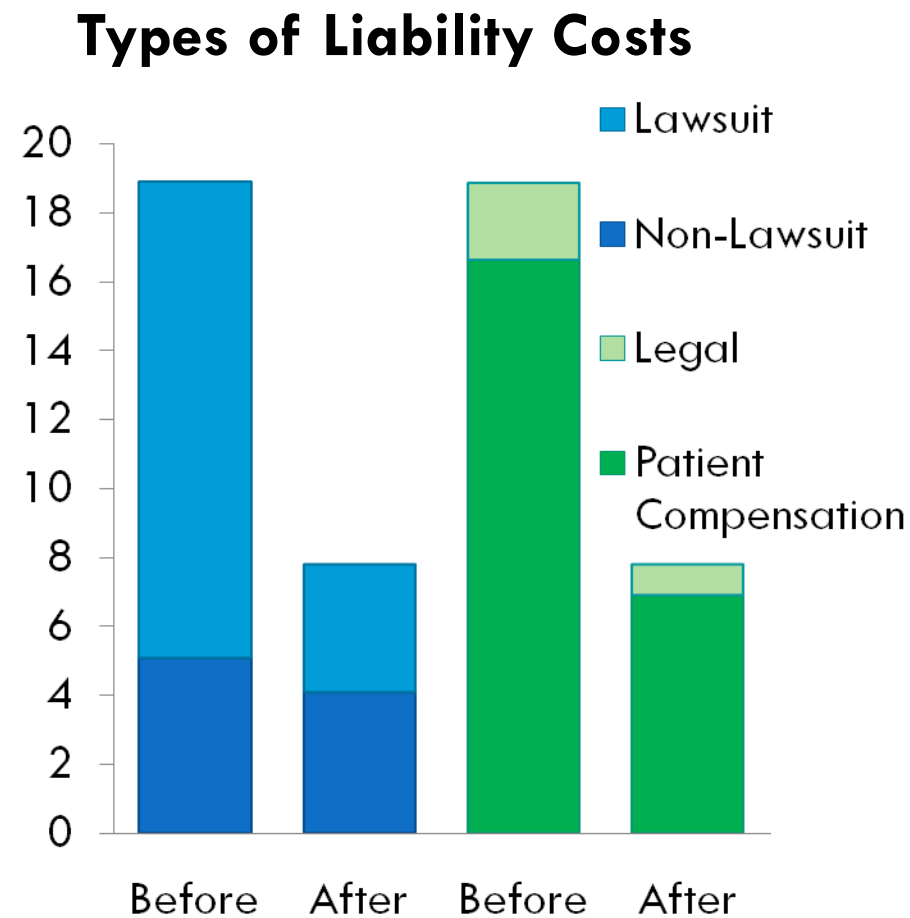


University of Michigan Health System

# Does it Work?



Mean Costs per month per \$1000 revenue



Kachalia et al, Ann Intern Med 2010

Claim = "any request for compensation for an unanticipated medical outcome whether initiated by the patient or by disclosure."

# CARe at Stanford University Medical Center

- Started their program in 2007
- Results from September 2007 to February 2011 showed that
  - Overall cost of claims is decreasing
  - 36% reduction in number of claims versus the two year period prior to the program
  - Saved \$3.2 million annually on premiums

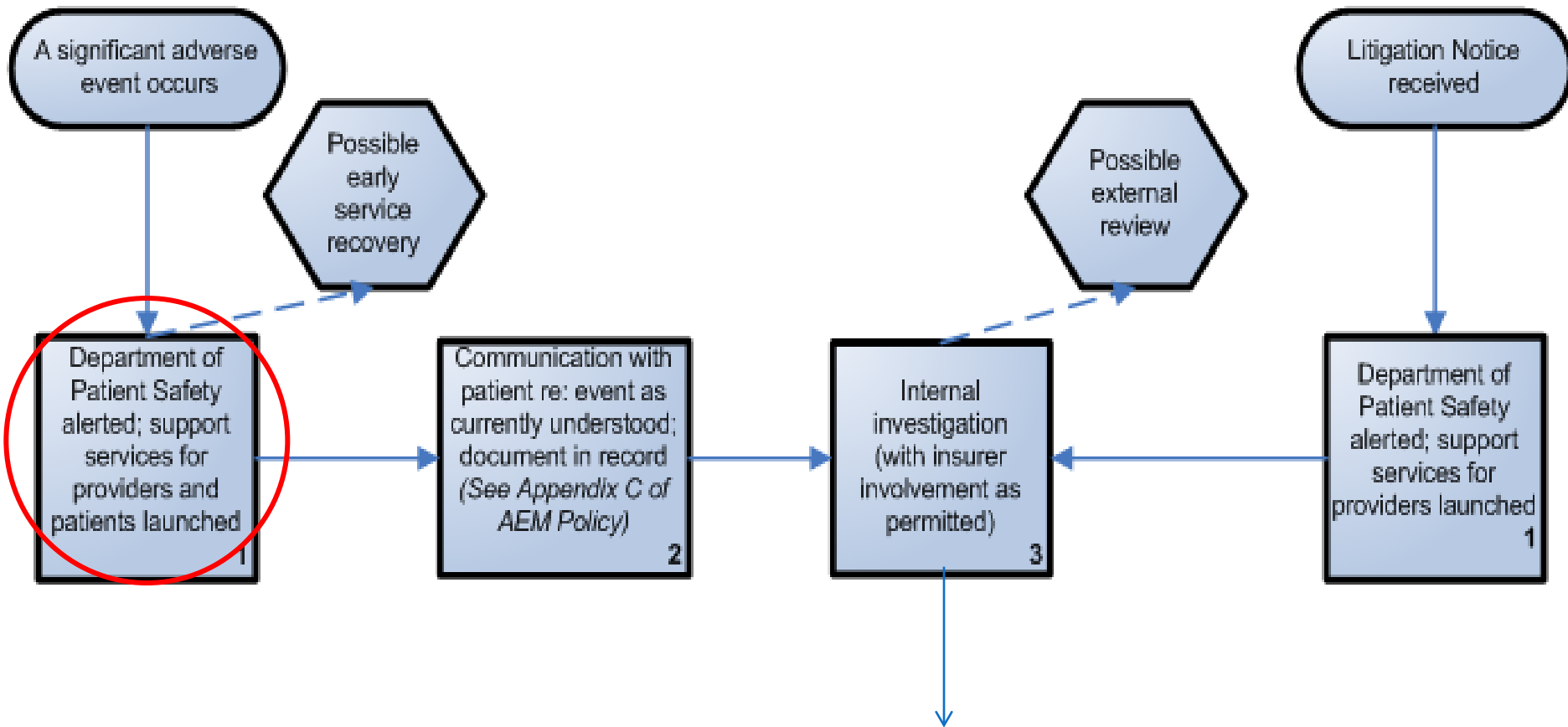


Conway J, Federico F, Stewart K, Campbell MJ. *Respectful Management of Serious Clinical Adverse Events (Second Edition)*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011.

# MACRMI: Activities

- Study Headquarters: BIDMC
- Pilot new model for communication and resolution at several volunteer institutions
  - BIDMC
  - BID Needham
  - BID Milton
  - Baystate Medical Center
  - Baystate Franklin
  - Baystate Mary Lane
- Create Centralized set of resources in Massachusetts to promote Communication and Resolution
  - MA Coalition for Prevention Medical Errors – Headquarters
  - BORM
  - MHA
  - MITSS
  - Mass Medical Society

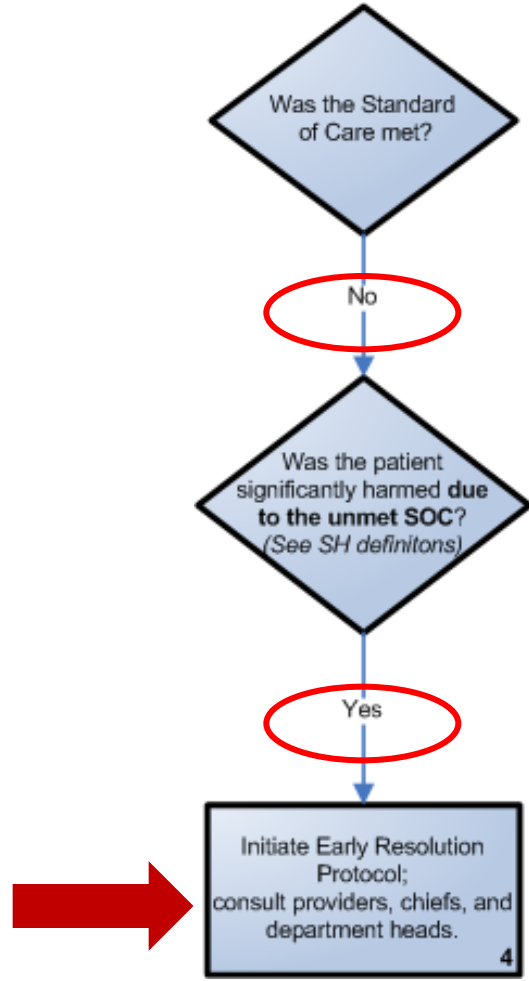
# Moving to a Standardized Approach





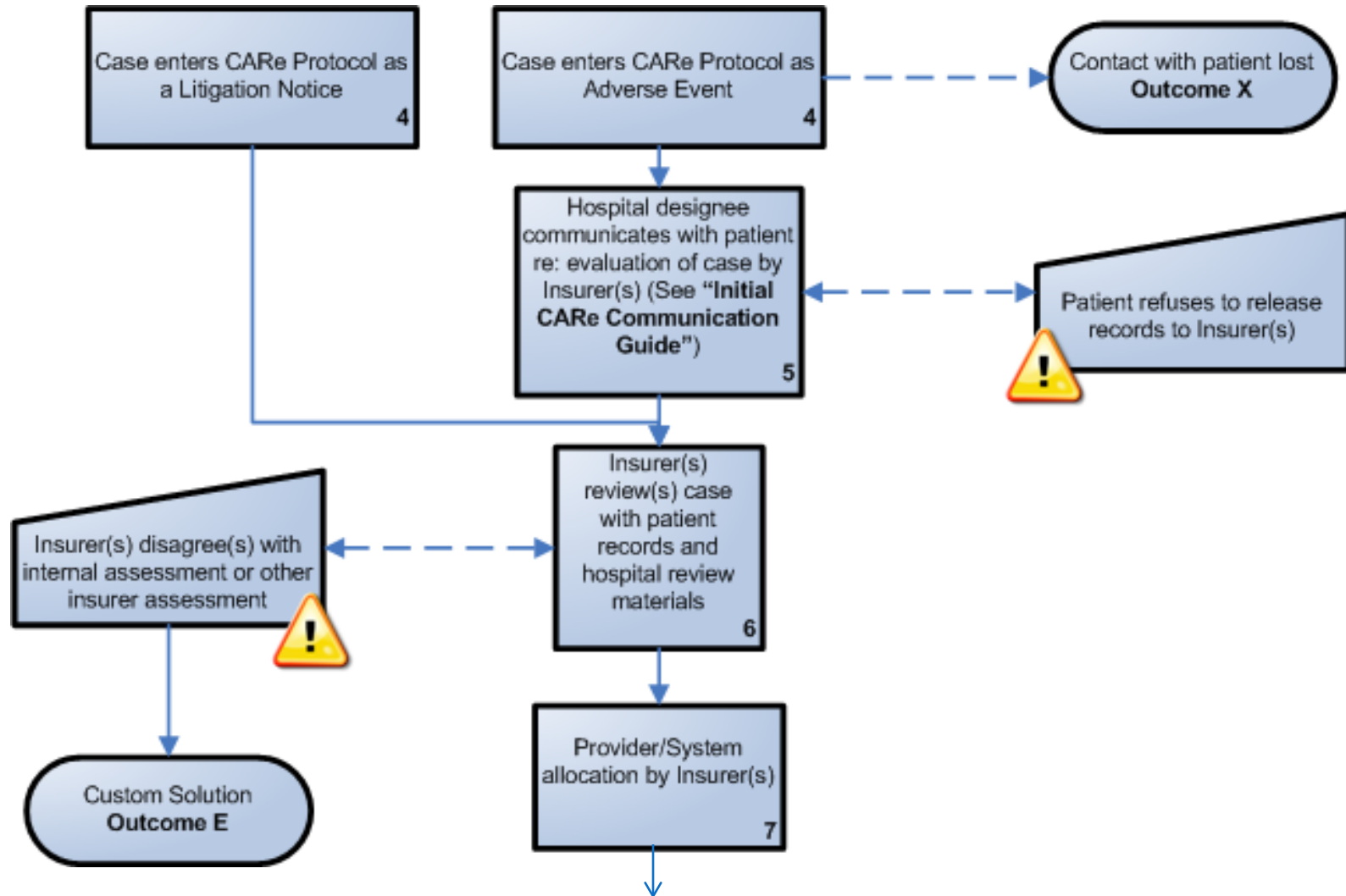
# When is the CARE Protocol used?

- Used for adverse events where an internal investigation team determines that
  - The standard of care was **not** met, AND
  - The unmet standard of care **caused** significant harm
  - OR when a Notice of Claim has been filed



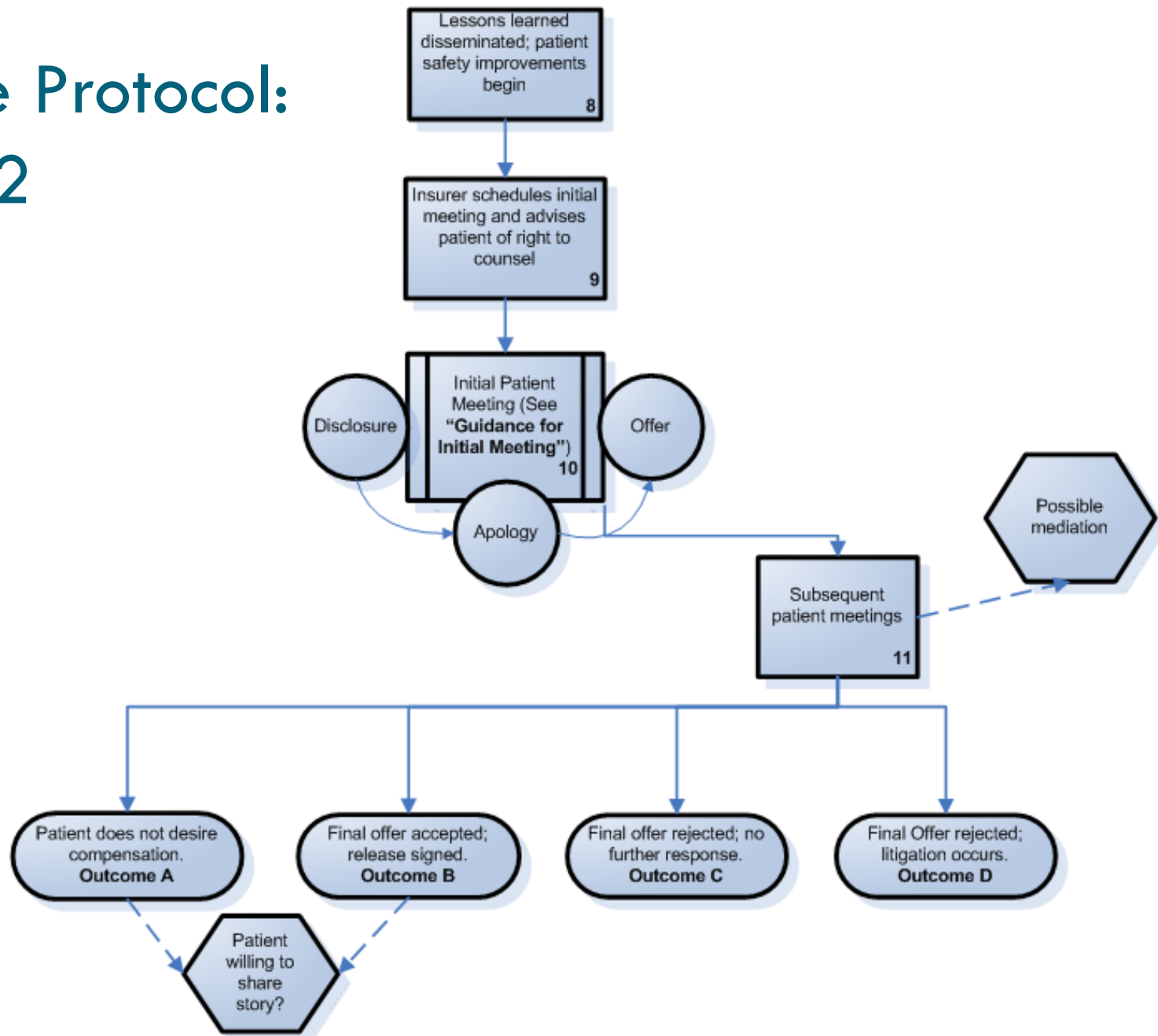
# CARe Protocol:

## Part 1



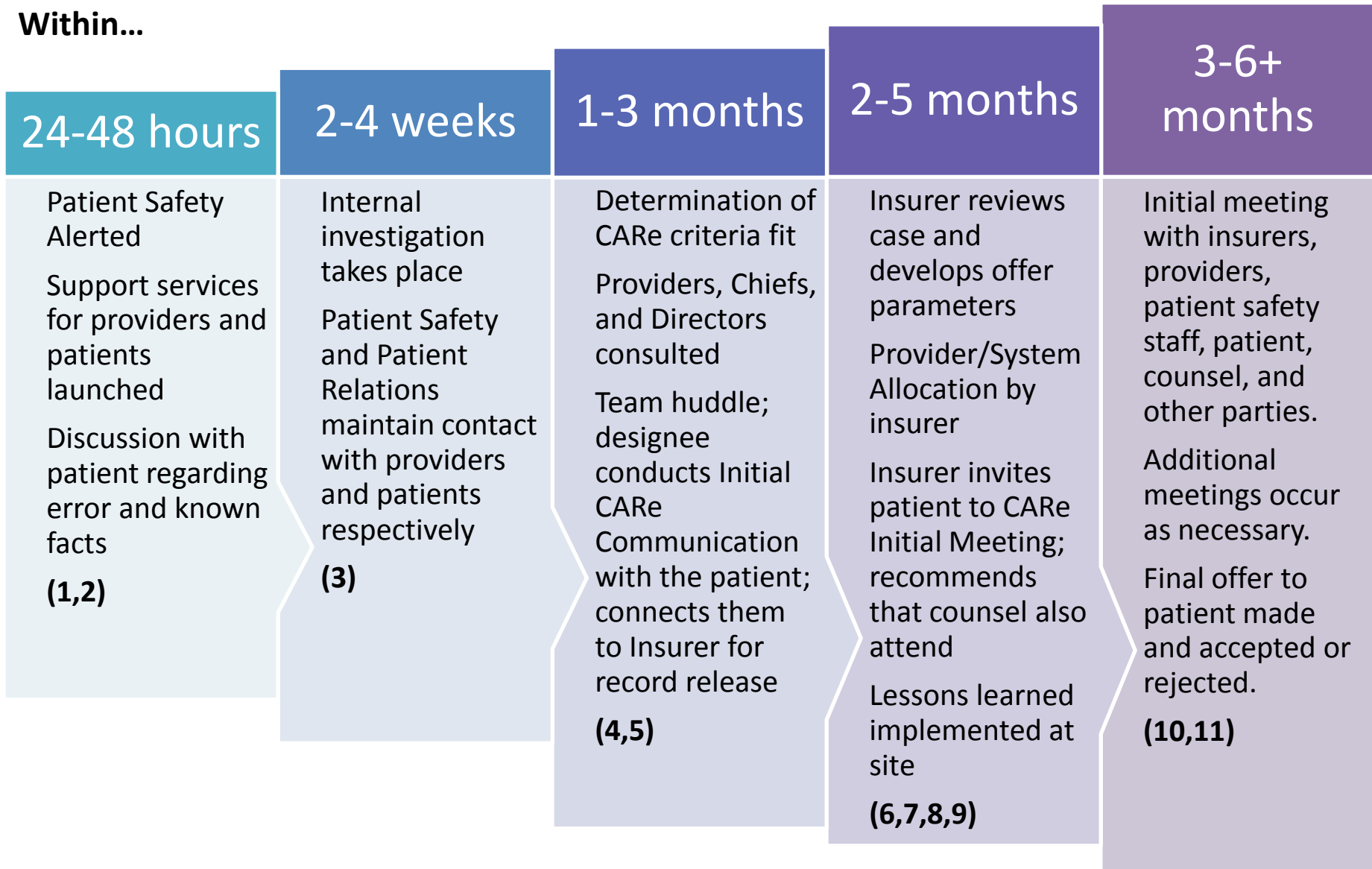


# CARe Protocol: Part 2



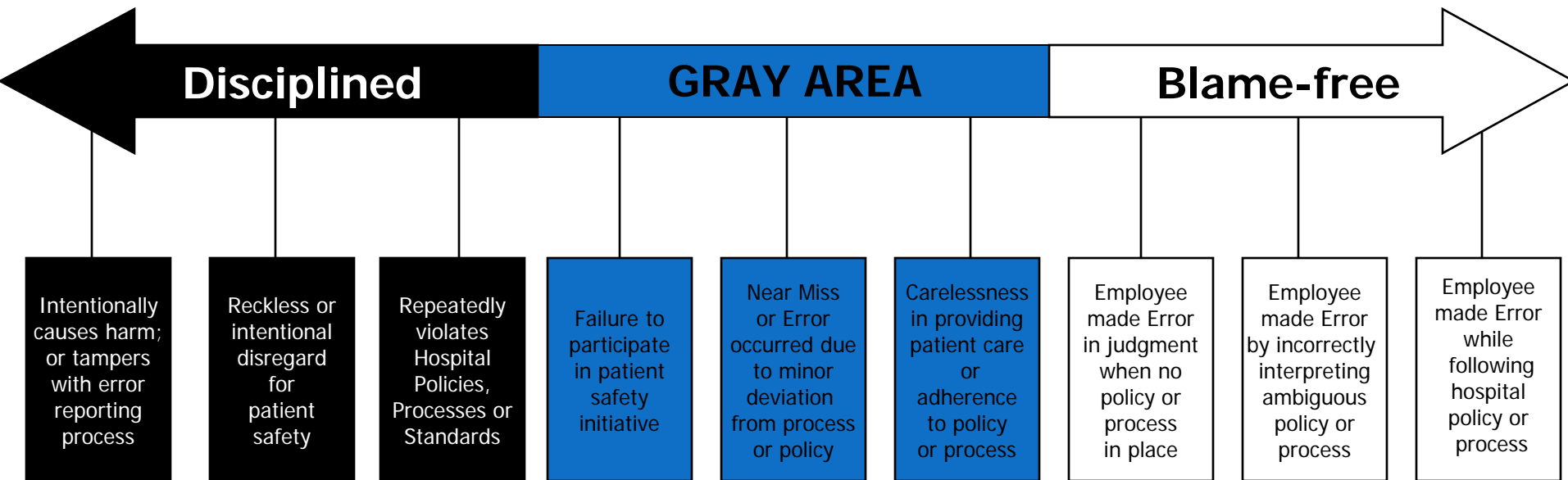
# Communication, Apology and Resolution Timeline

Within...



# Issues Regarding Reporting:

## MACRMI endorses the use of *Just Culture* Framework



### Principles

- 1) All humans are capable of human error. The organization is responsible for ensuring that reliable systems keep common errors from causing harm.
- 2) Association with an event is not equivalent to responsibility for an event
- 3) Severity of outcome should *not* determine severity of discipline
- 4) Degree of recklessness **should** determine severity of discipline, regardless of severity of outcome

# CARe Pilot: Assessment Strategy

- Volume and Financial Outcomes
  - Occurrence of events
    - Pre-claim settlements
    - Claims
    - lawsuits
  - Costs
    - Litigation and non-litigation expenses
    - Costs going directly to patients
- Clinician experience (proposed, not yet funded)
- Patient Experience (proposed, not yet funded).

# Hospital Operational Requirements for Successful CARe Implementation

- Strong endorsement by Leadership (physician and administrative)
- Well established working collaboration with Liability Insurer
  - Agreement on Goals of initiative
  - Agreement on Logistics
- Strong Internal Risk Management Program Willing to Coordinate the Effort
- Reliable systems for reporting adverse events

# Hospital Operational Requirements for Successful CARe Implementation

- Well Coordinated Communication Strategy
- Education of Workforce regarding the CARe model
  - Targeted Presentations for clinicians, leadership, staff
  - Immediate reference sources, such as badge cards
- Support for Clinicians
  - “Just in time” support and coaching for a difficult communication (“disclosure”) in immediate aftermath of an adverse event
  - Longer term support regarding the process for early resolution and implications for reporting

# The Potential Payoff

*I think it'll be a huge win for patients, a huge win. I think they suffer as much as anybody in the courts, maybe more. It'll be a huge win for providers emotionally. It will be a huge win from a financial perspective because the right people will be getting compensated in a more timely manner and there will be far less waste in the process. That's a lot of benefits."*

*– A hospital representative*

# Contact Information

Kenneth Sands, M.D., M.P.H. –  
[ksands@bidmc.harvard.edu](mailto:ksands@bidmc.harvard.edu)

Alan Woodward, M.D. –  
[woodward@massmed.org](mailto:woodward@massmed.org)

Melinda Van Niel, M.B.A. (project manager) —  
[mvanniel@bidmc.harvard.edu](mailto:mvanniel@bidmc.harvard.edu)