First Annual CARe Forum

Massachusetts Medical Society

April 26, 2013

Transforming Medical Liability in Massachusetts: Background, Accomplishments, and Updates

Alan C. Woodward, MD
Past President and Chair of Committee on Professional Liability
Massachusetts Medical Society

Background: Investigation and Planning

- Failings of current system
- Options for reform (taskforce)
- Disclosure, Apology and Offer
- Evidence and Advantages
- AHRQ Planning Grant
- Roadmap for State

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Failings of the current system

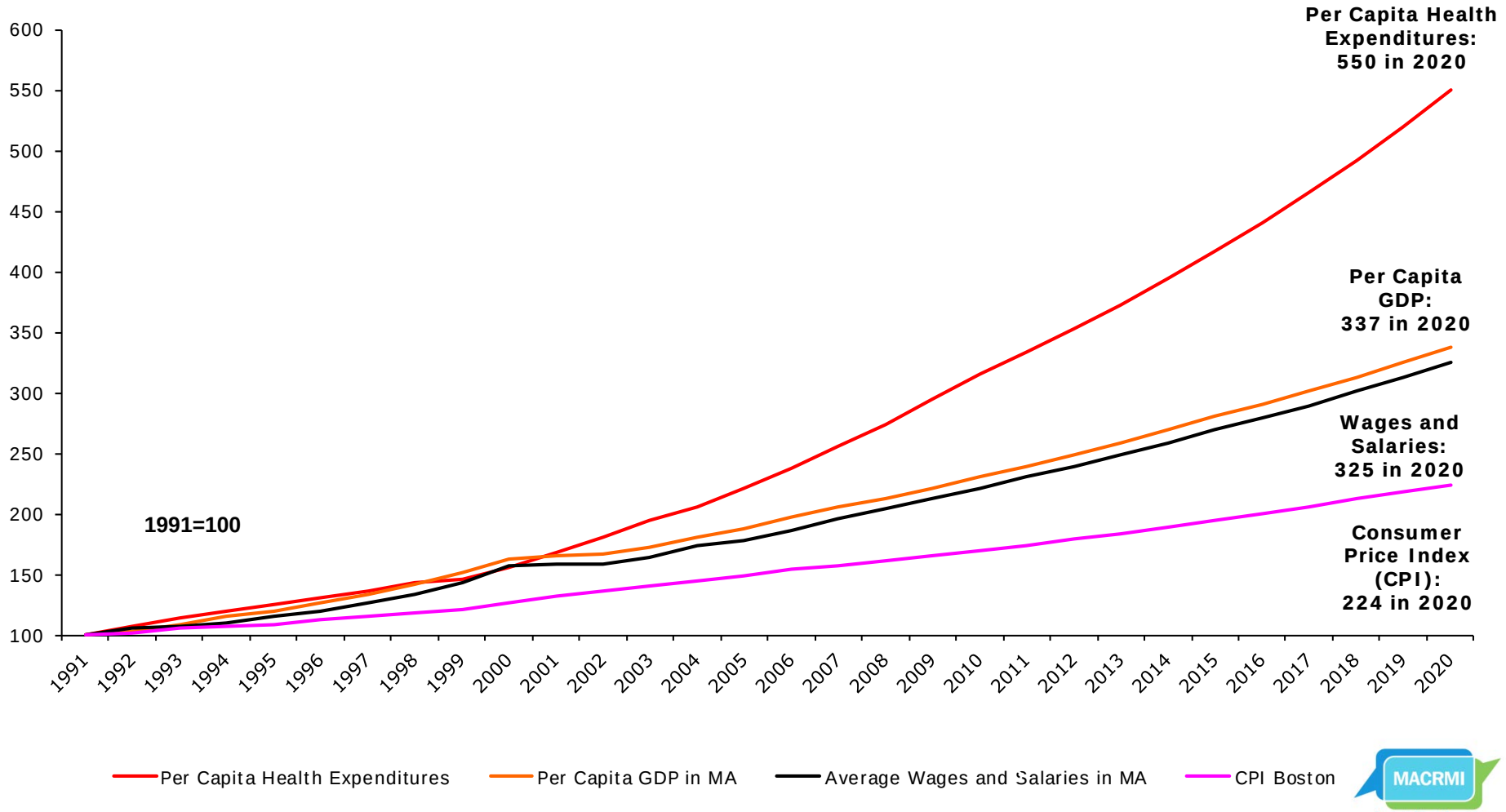
Patients - unfair, slow, inequitable, inefficient, isolating and no apology

Physicians - expensive, stressful, impacts health, modify practice and motivates defensive medicine

Healthcare system - compromises patient safety, workforce and access to care and drives defensive medicine, healthcare costs and number of underinsured

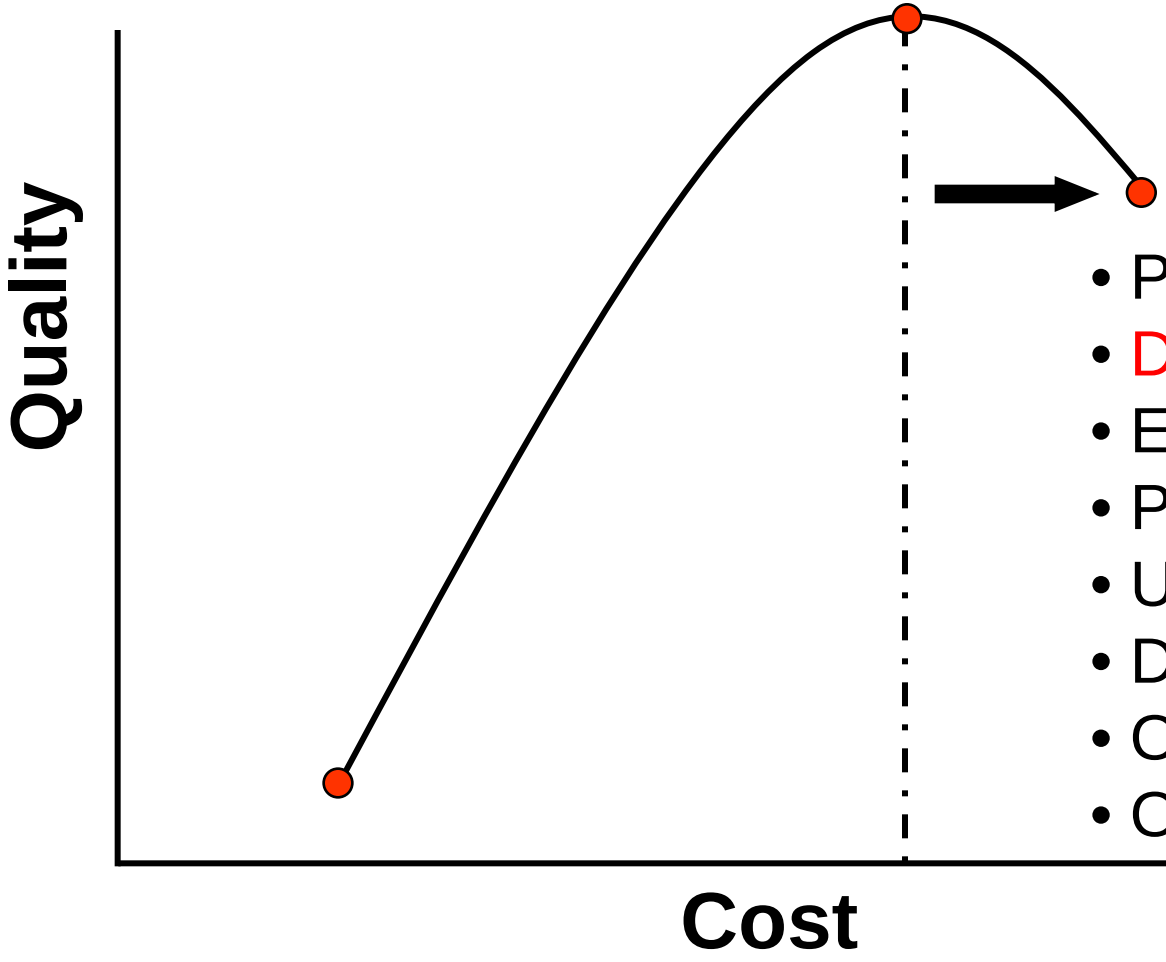
MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Rising Costs



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

Overuse: Resource Drivers



- Payment system
- Defensive medicine
- End of life care
- Poor Communication
- Unrealistic expectations
- DTC advertising
- Overregulation
- Others

The result . . .

"The current liability system is the number one toxic impediment to patient safety improvement."

-Lucian Leape, Harvard School of Public Health

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

- Michelle Mello, Harvard School of Public Health

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

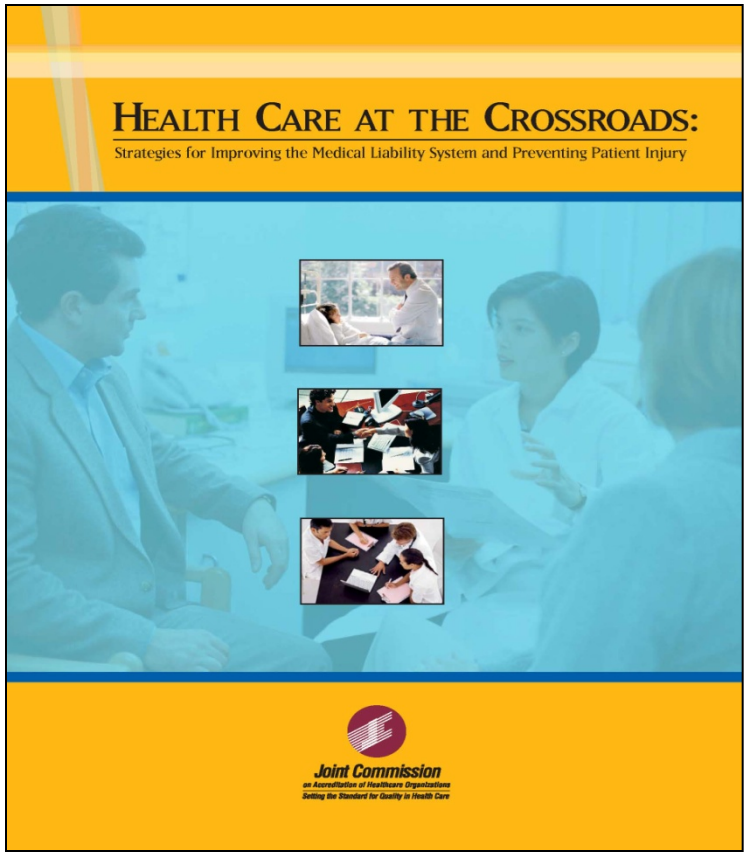
MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Options for Reform

- Tort system alternative
- A fundamentally different system
  - Fair, efficient, reliable, just and accountable
  - Supports patient safety improvement
  - Reduces the fear driving defensive medicine

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

DA&O Components



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

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Principles of DA&O

- 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

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Evidence: University of Michigan

- 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
- Stopped buying reinsurance
- Reduced reserves $72M to $19M, funding patient safety initiatives
- Court cases reduced more than 90% (1-2/yr)
- Provide unlimited coverage with lower premiums
- Incident reporting - increased many fold
- Culture change - fear factor reduced - don’t teach DM

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Advantages (Transformational)

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

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

AHRQ Planning Grant

Sponsorship:

- **1 Year planning grant**
- **$300 K**
- **Agency for Healthcare Research and Quality**
- **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

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

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 for barriers were evaluated by frequency mentioned, feasibility, importance and time frame
- Road Map drafted and circulated back to interviewees then presented

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Barriers to DA&O Model Implementation

Barrier*	# of Respondents
Charitable immunity law	22
Physician discomfort with disclosure & 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*

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 / broad adoption
- Data Collection and Dissemination

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Summary

- Overall perception of DA&O was very favorable
  - Positive effects on patient safety frequently noted and it is the right thing to morally and ethically
  - No alternative viewed more favorably
- Most suggested strategies to overcome the twelve identified barriers were feasible
- Other stakeholders were highly interested

Implementation: Accomplishments
(last 12-18 months)

- Secured local funding
- Developed our Alliance (MACRMI) and CARe
- Released Roadmap / Media Campaign
- Established Pilot Program in varied sites
- Enacted Consensus Enabling Legislation
- Launched Website
- Developed Education Programs and Materials and Best Practices

Funding for Implementation

- AHRQ - $3M / 3Yr Demonstration Grant
  - $50M in ACA - no appropriation

- Local sources - all contributed
  - CRICO and BHIC for pilots
  - BCBS, HPHC, TAHP
  - Coverys, MMS & Reliant

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

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
- BORIM - Reporting / Dissemination
- MITSS - Patient Education / Advocacy
- MBA – Patient Advocacy / Education
- HSPH - Assessment
- UM - Policies / Workbook / Coaching

MACRMI and CARe

MITSS
Medically Induced Trauma Support Services

CRICO RMF Protecting providers. Promoting safety.

COVERYS

MBA

Massachusetts Medical Society
Every physician matters, each patient counts.

Beth Israel Deaconess Medical Center

Baystate Health

MHA Massachusetts Hospital Association
The leading voice for hospitals.

Massachusetts Coalition for the Prevention of Medical Errors

Board of Registration in Medicine

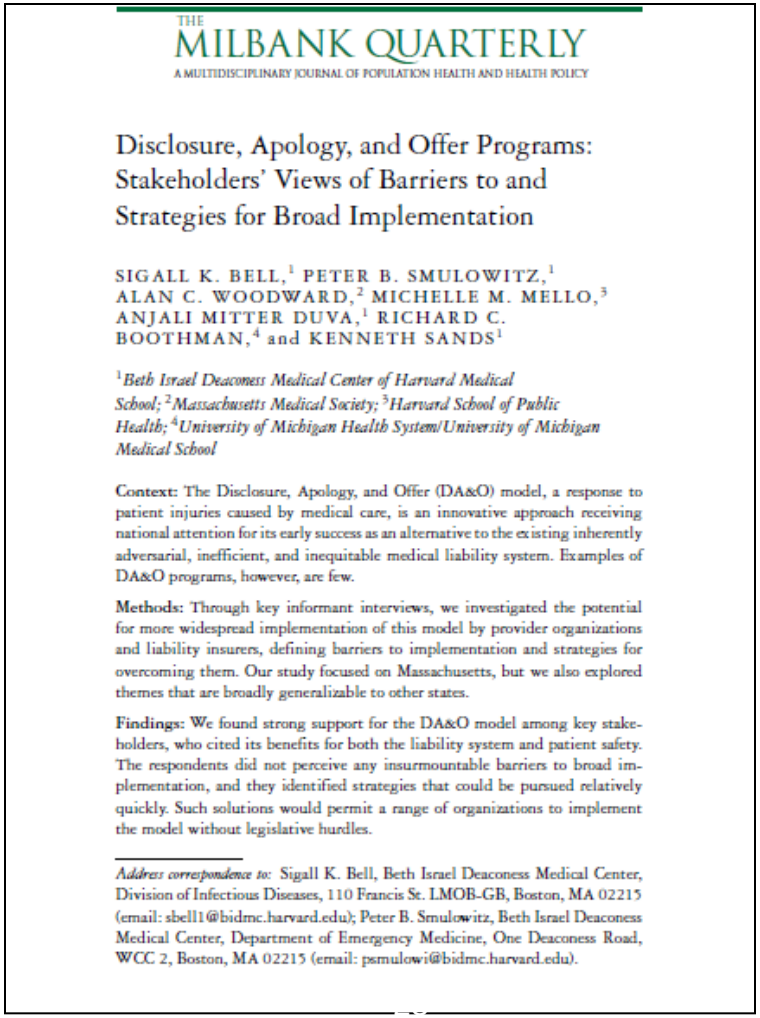
=

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

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

Roadmap Released - Media

- Released April 2012- >300 Media Outlets
- Press releases on our Consensus Language and Website Launch
- Study published in the Milbank Quarterly, December 2012:



THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Disclosure, Apology, and Offer Programs: Stakeholders' Views of Barriers to and Strategies for Broad Implementation

SIGALL K. BELL,[1] PETER B. SMULOWITZ,[1] ALAN C. WOODWARD,[2] MICHELLE M. MELLO,[3] ANJALI MITTER DUVA,[1] RICHARD C. BOOTHMAN,[4] and KENNETH SANDS[1]

[1]*Beth Israel Deaconess Medical Center of Harvard Medical School;* [2]*Massachusetts Medical Society;* [3]*Harvard School of Public Health;* [4]*University of Michigan Health System/University of Michigan Medical School*

Context: The Disclosure, Apology, and Offer (DA&O) model, a response to patient injuries caused by medical care, is an innovative approach receiving national attention for its early success as an alternative to the existing inherently adversarial, inefficient, and inequitable medical liability system. Examples of DA&O programs, however, are few.

Methods: Through key informant interviews, we investigated the potential for more widespread implementation of this model by provider organizations and liability insurers, defining barriers to implementation and strategies for overcoming them. Our study focused on Massachusetts, but we also explored themes that are broadly generalizable to other states.

Findings: We found strong support for the DA&O model among key stakeholders, who cited its benefits for both the liability system and patient safety. The respondents did not perceive any insurmountable barriers to broad implementation, and they identified strategies that could be pursued relatively quickly. Such solutions would permit a range of organizations to implement the model without legislative hurdles.

Address correspondence to: Sigall K. Bell, Beth Israel Deaconess Medical Center, Division of Infectious Diseases, 110 Francis St. LMOB-GB, Boston, MA 02215 (email: sbell1@bidmc.harvard.edu); Peter B. Smulowitz, Beth Israel Deaconess Medical Center, Department of Emergency Medicine, One Deaconess Road, WCC 2, Boston, MA 02215 (email: psmulowi@bidmc.harvard.edu).

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**

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Pilot Sites for CARe Program

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

Enrollment Start Date: December 1, 2012

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

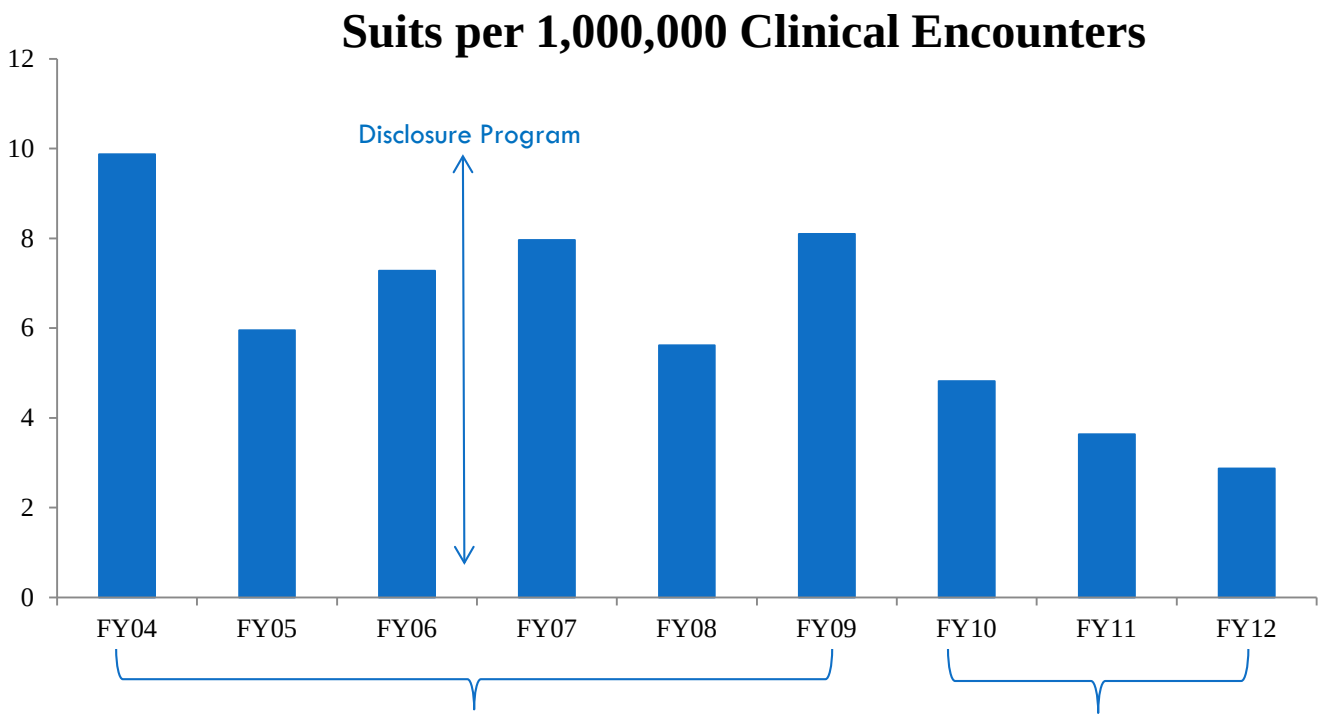
Website: **www. macrmi.info**

HORIZON INTERACTIVE AWARDS BRONZE WINNER

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Updates

- Reporting - NPDB and BORIM
- Other States - Oregon
- Data from MA - Reliant



The decrease in Suits for last three years (FY10-FY12) is **statistically**

Conclusion - Multiple Benefits

Right and Smart thing to do

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

THE PILOT SITES: PROCESSES AND PROGRESS

Kenneth Sands, MD MPH

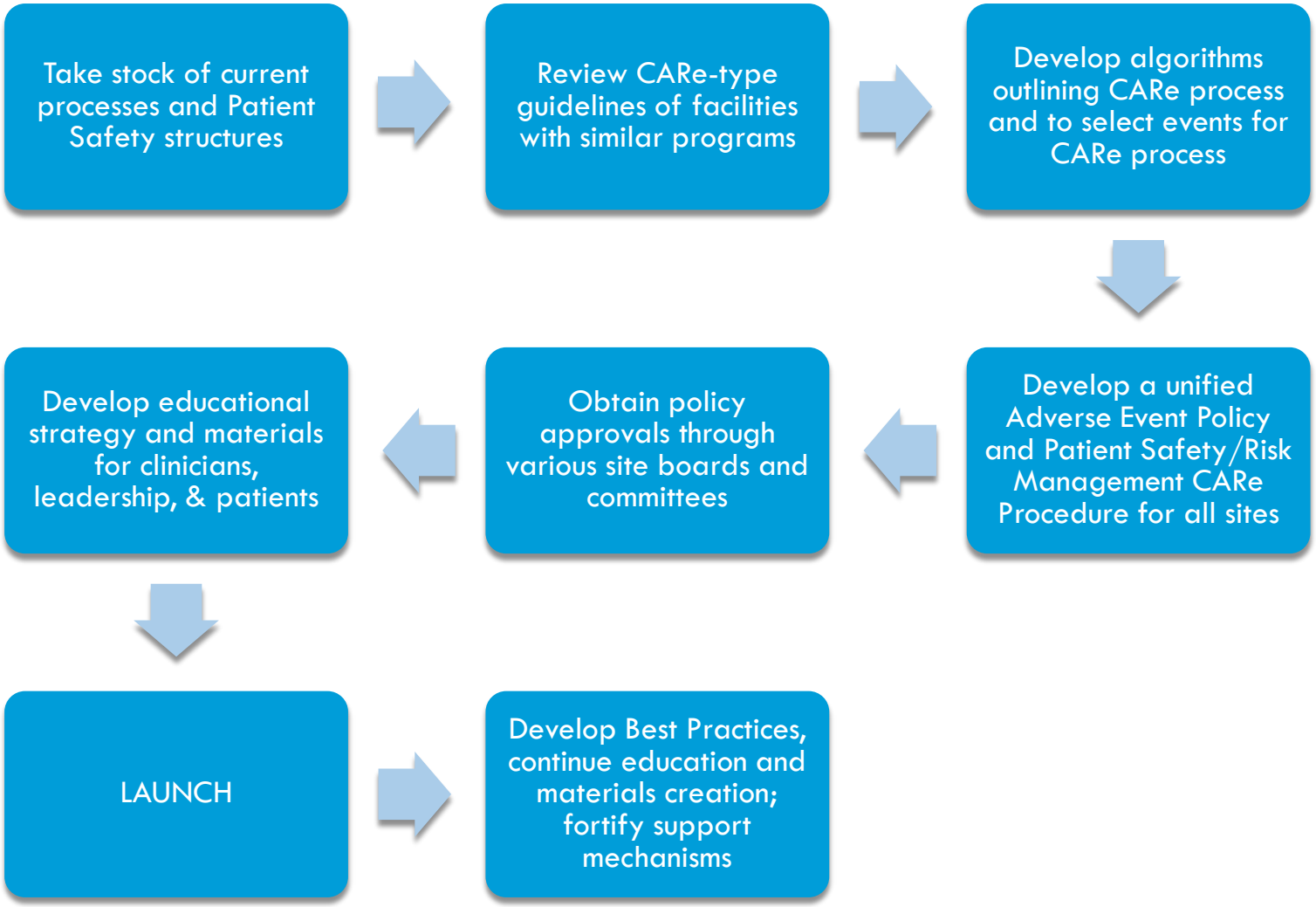
Senior Vice President, Health Care Quality

Beth Israel Deaconess Medical Center

The Massachusetts Pilot Sites

Site	#Beds	Location	Teaching (Y/N)
Beth Israel Deaconess Medical Center	642	Inner City	Y
BID-Milton	88	Community	N
BID-Needham	58	Community	N
Baystate Medical Center	716	Inner City	N
Baystate Franklin Medical Center	93	Community	N
Baystate Mary Lane Hospital	31	Community	N

A Path to CARe Implementation

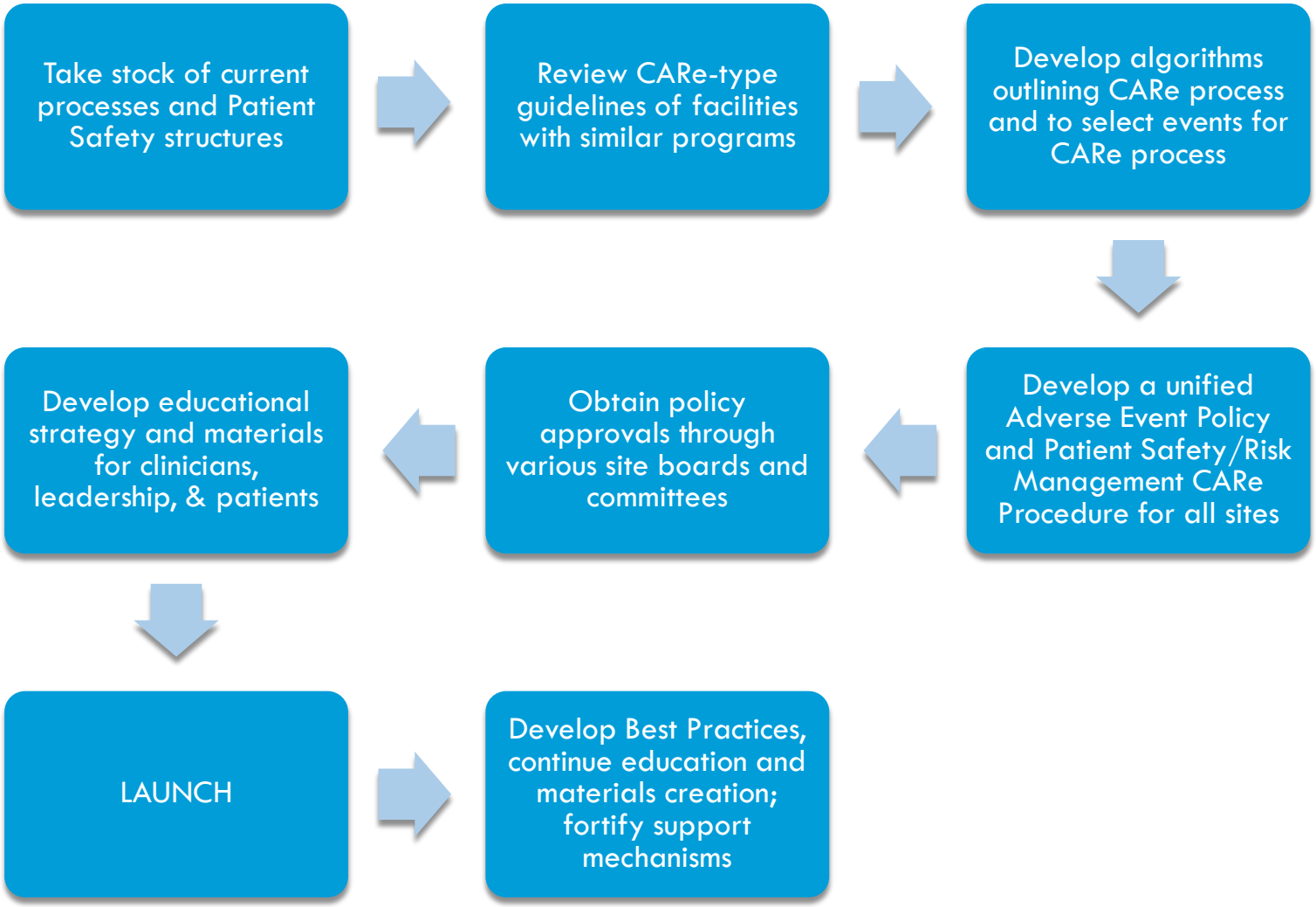


MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Take Stock of Current Processes

- Determined what adverse event procedures already exist, and their compatibility with CARe principles
- Worked with front-line risk/safety staff to determine their perceptions about CARe and solicit ideas for ways that CARe might fit into current processes
- Found common elements in processes among all sites and worked together from that commonality

A Path to CARe Implementation

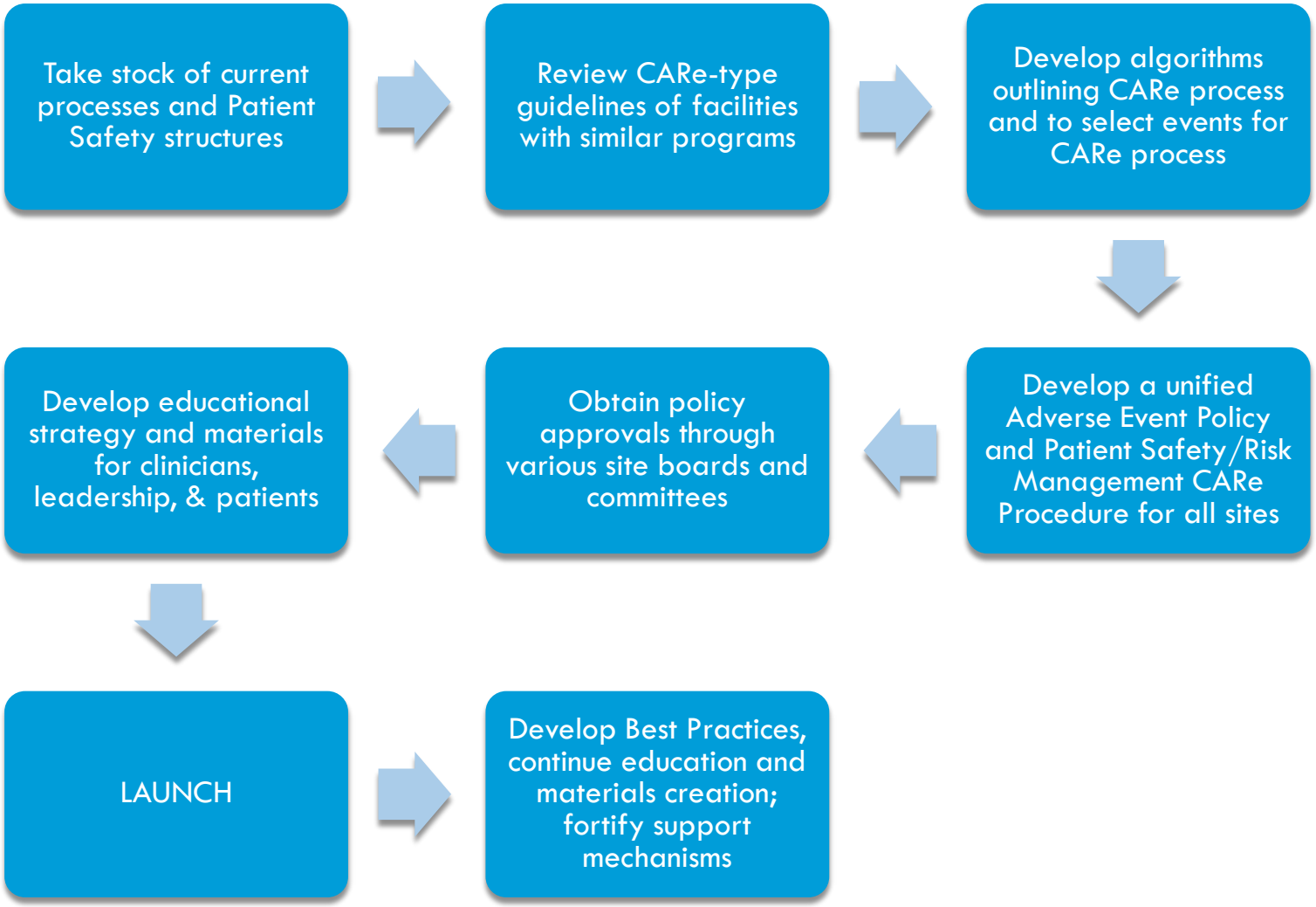


MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Review data and resources from other CARe Programs

- We reviewed policies, algorithms, guides, etc. from:
  - The University of Michigan Health System
  - The University of Washington
  - Stanford Hospital and Clinics
- Goal: To determine what pieces of existing work will integrate well with our systems and what still needs to be developed due to the unique attributes of Massachusetts' medical liability environment

A Path to CARe Implementation



MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Develop Algorithms

There are two CARe Algorithms:

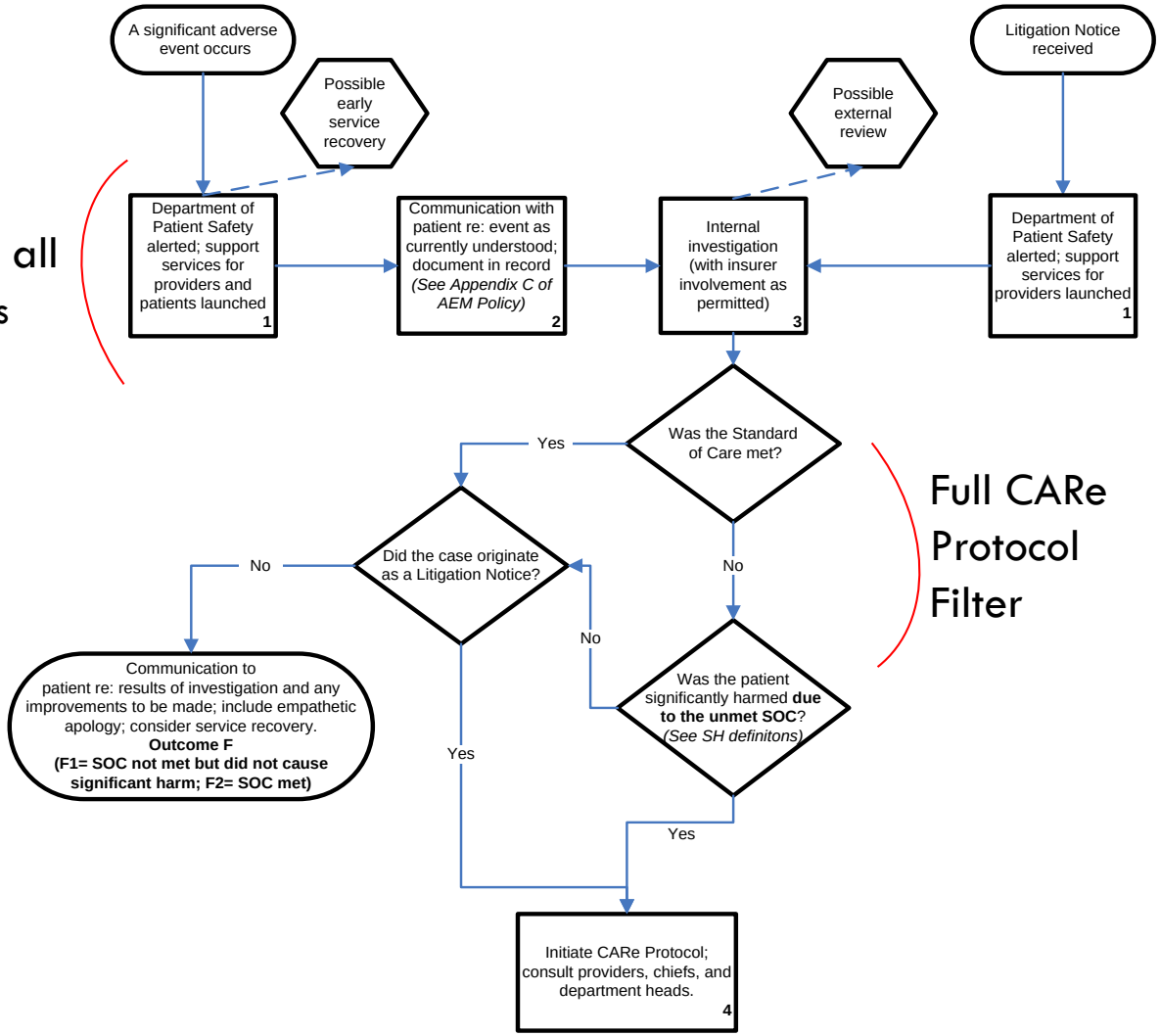
- A “filter” to determine whether an adverse event case should go through the full CARe process
  - **“Defining a CARe Case”**
- The full CARe process that will be followed if a case is selected by the filter
  - **“CARe Protocol”**

“Defining a CARe Case” Algorithm

Process followed for all A.E.s (includes support)

Service Recovery Possibility for Non-Protocol Cases

Full CARe Protocol Filter



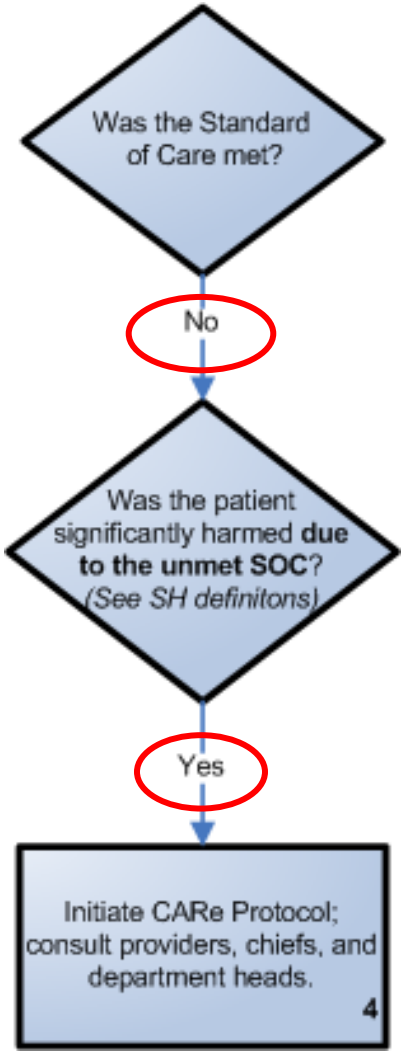
“Defining a CARe Case” –the Filter

If an internal investigation team determines that…

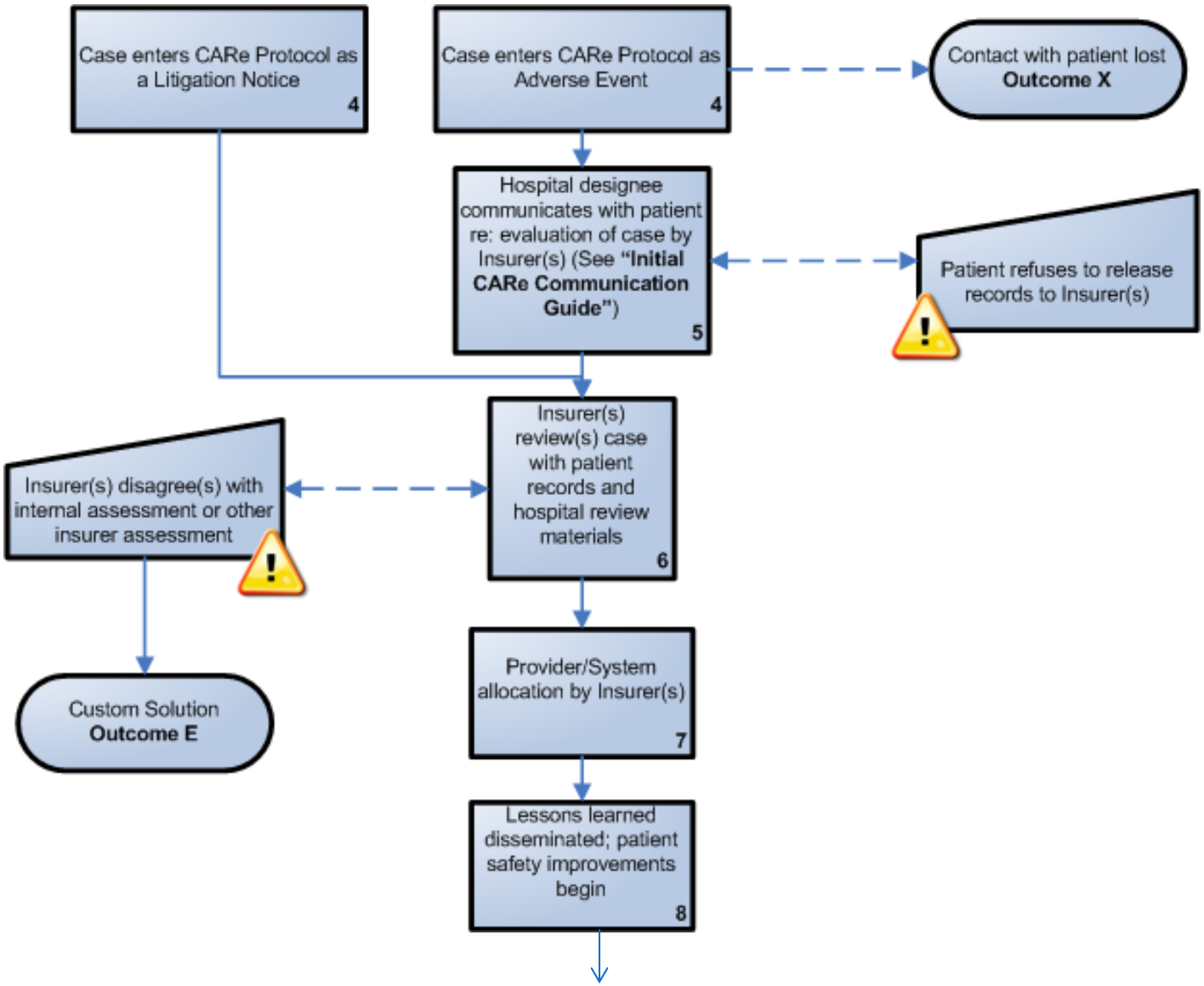
- The standard of care was **not** met, AND
- The unmet standard of care **caused** significant harm

…the case moves to the full **CARe Protocol**

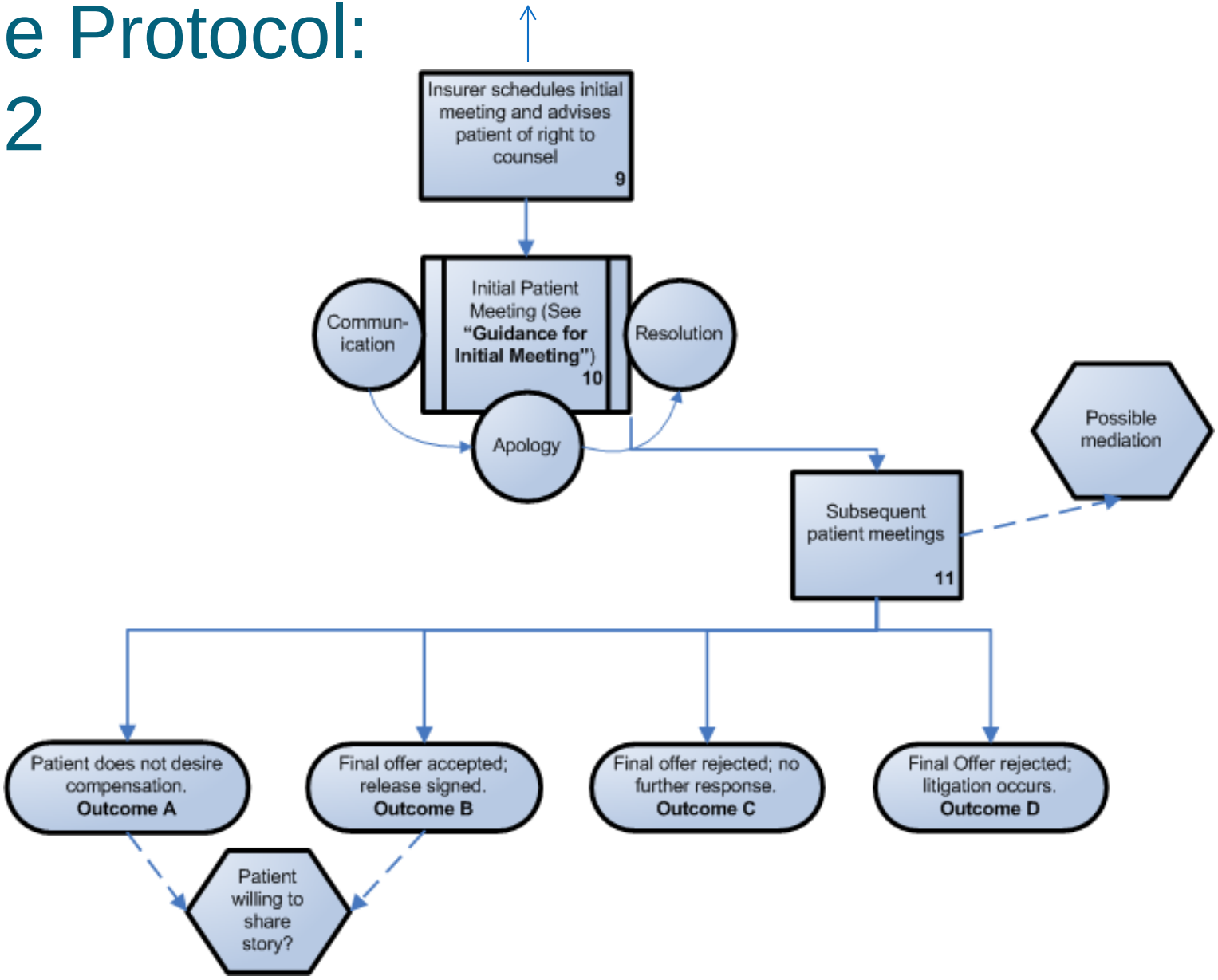
(Pre Litigation Notices move directly into the protocol)



CARe Protocol: Part 1



CARe Protocol: Part 2



Communication, Apology and Resolution Timeline

Within…

24-48 hours

- Patient Safety Alerted
- Support services for providers and patients launched
- Discussion with patient regarding error and known facts

(1,2)

2-4 weeks

- Internal investigation takes place
- Patient Safety and Patient Relations maintain contact with providers and patients respectively

(3)

1-3 months

- Determination of CARe criteria fit
- Providers, Chiefs, and Directors consulted
- Team huddle; designee conducts Initial CARe Communication with the patient; connects them to Insurer for record release

(4,5)

2-5 months

- Insurer reviews case and develops offer parameters
- Provider/System Allocation by insurer
- Insurer invites patient to CARe Initial Meeting; recommends that counsel also attend
- Lessons learned implemented at site

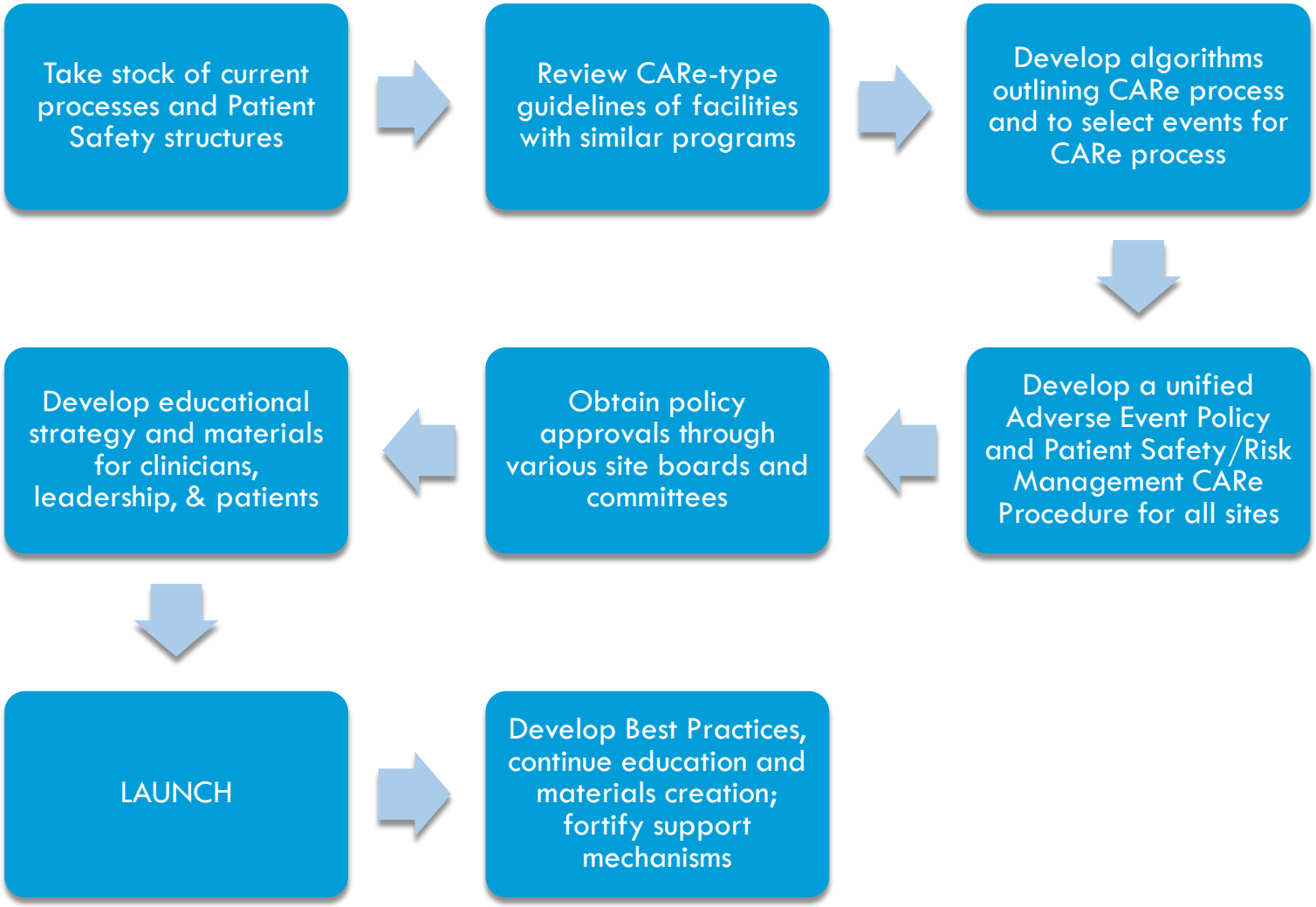
(6,7,8,9)

3-6+ months

- Initial meeting with insurers, providers, patient safety staff, patient, counsel, and other parties.
- Additional meetings occur as necessary.
- Final offer to patient made and accepted or rejected.

(10,11)

A Path to CARe Implementation



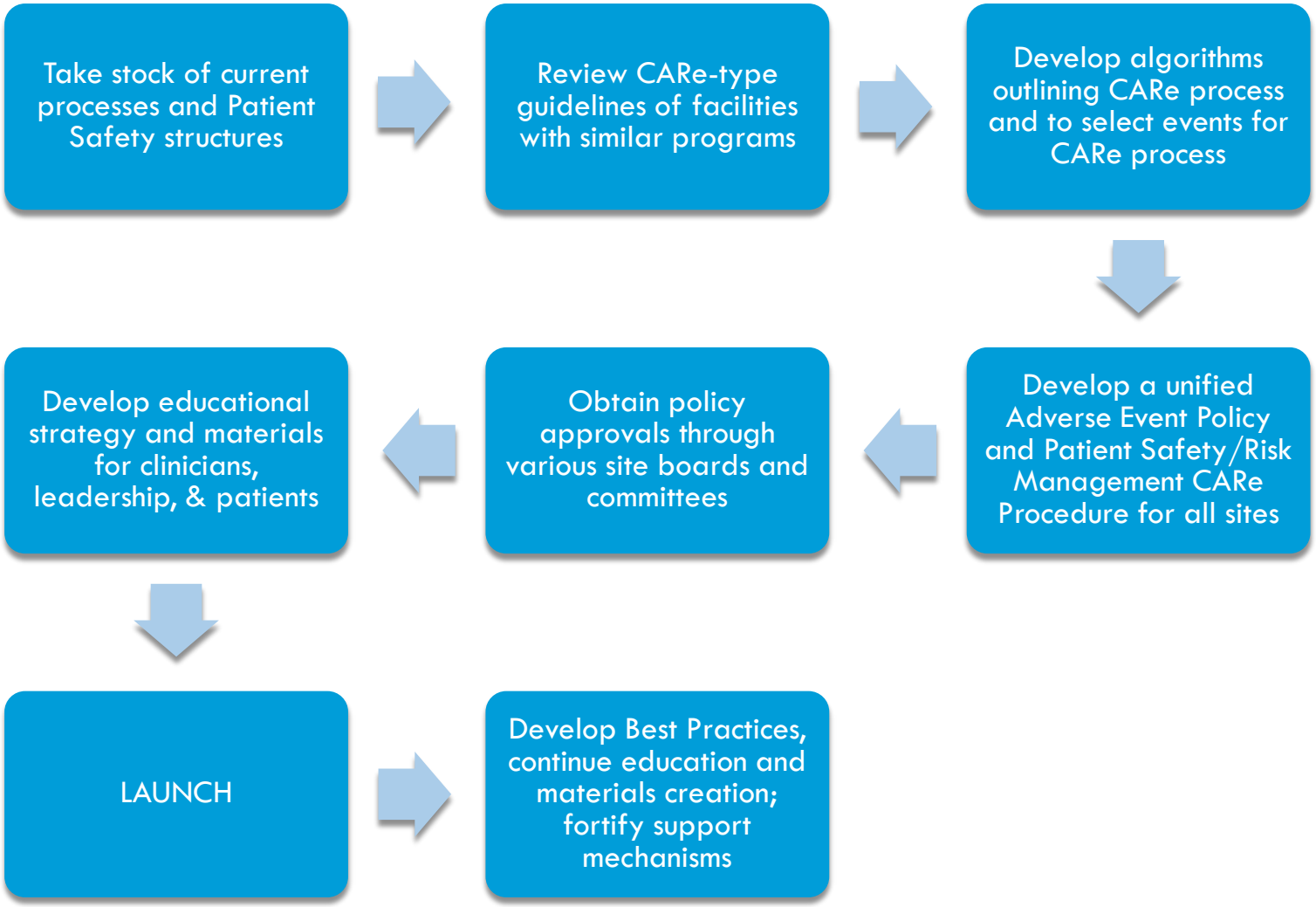
MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Develop a Unified Adverse Event Policy

- Developing a policy that works within all existing Adverse Event Policies at the sites was essential to the CARe program's functionality
- The central components of CARe were inserted into existing hospital policy in a non-disruptive way, and more in-depth procedures were developed for the risk/safety departments to use as "on-the-ground" reference guides
- Made sure that there were reliable systems for reporting adverse events at all sites

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

A Path to CARe Implementation



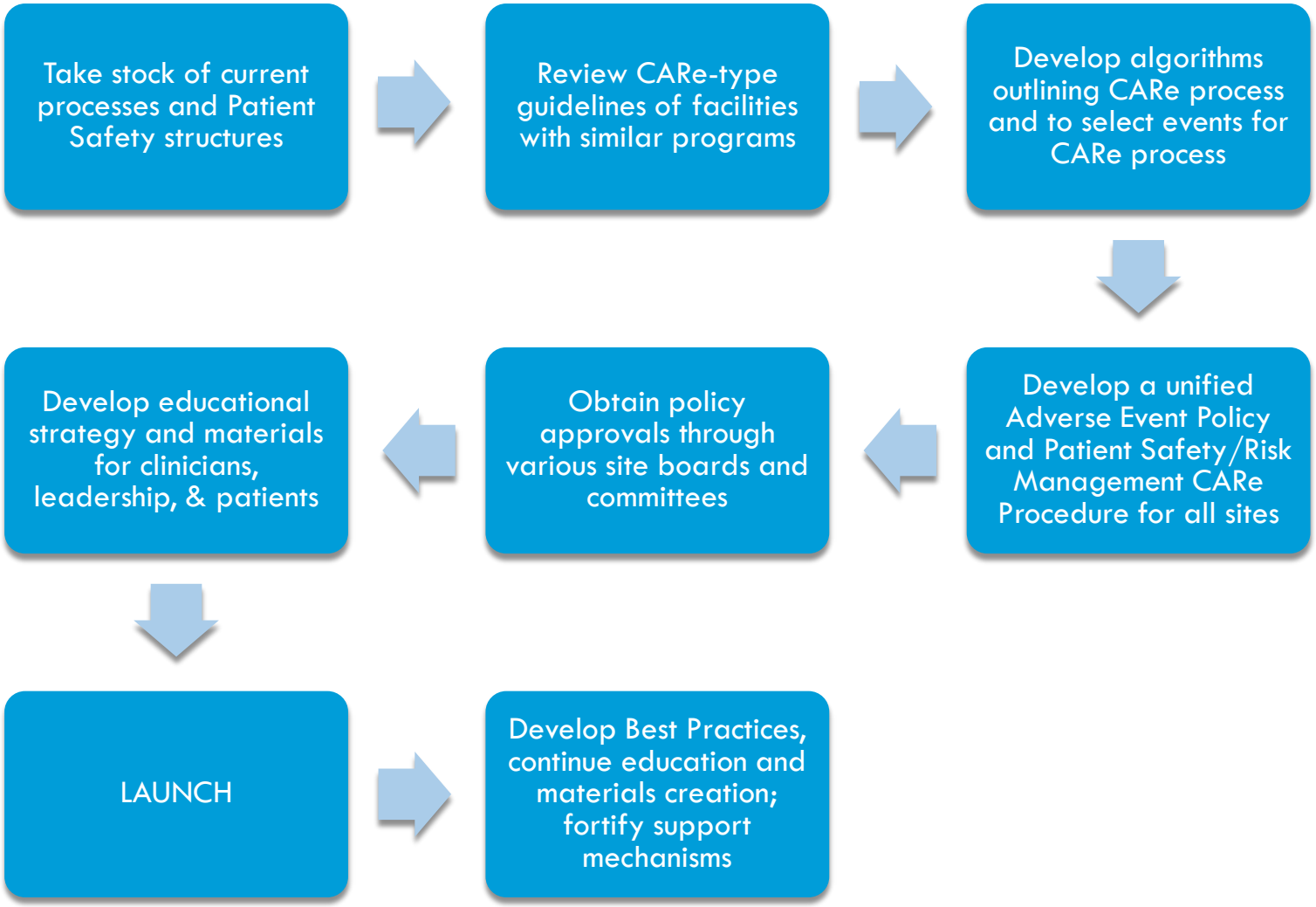
MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Obtain Leadership Approval and Increase Buy-in

- All hospital boards and other central committees were presented the model and approved the policy
- This generated increased buy-in for the program and transformed it from “pilot” to “policy,” which will help to continue a positive culture change at each site
- Policies also reviewed by the Liability Insurers, as part of a well-established working collaboration including
  - Agreement on Goals of initiative
  - Agreement on Logistics

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

A Path to CARe Implementation

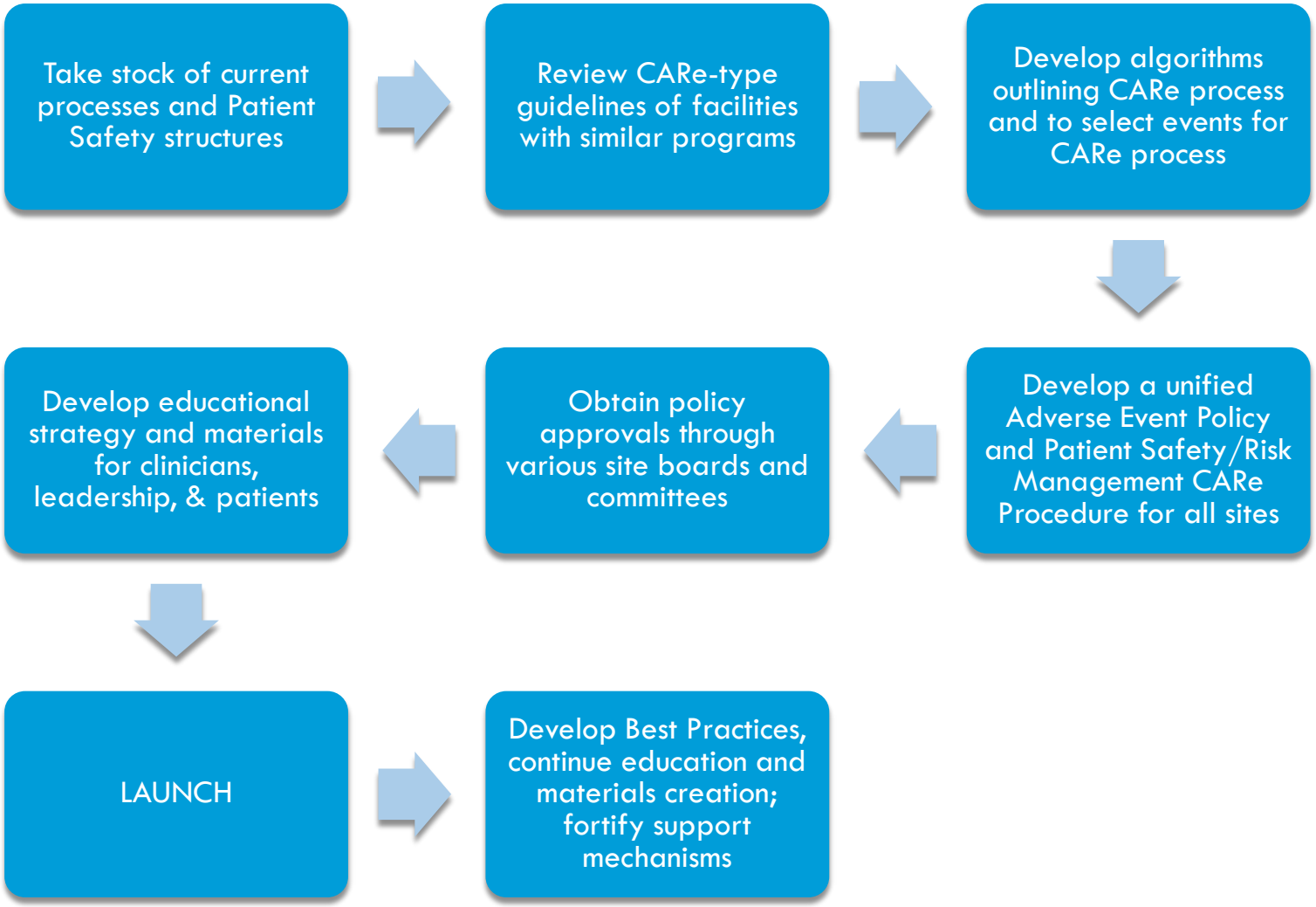


MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Develop Educational Strategy & Materials

- Strategy and materials
  - Targeted Presentations for clinicians, leadership, staff
  - Immediate reference sources; i.e. badge cards, posters
  - Website
- Multiple Reviewers of Materials
  - Clinicians
  - Patients and Families
  - Attorneys
  - Insurers
- Educate, educate, educate!

A Path to CARe Implementation



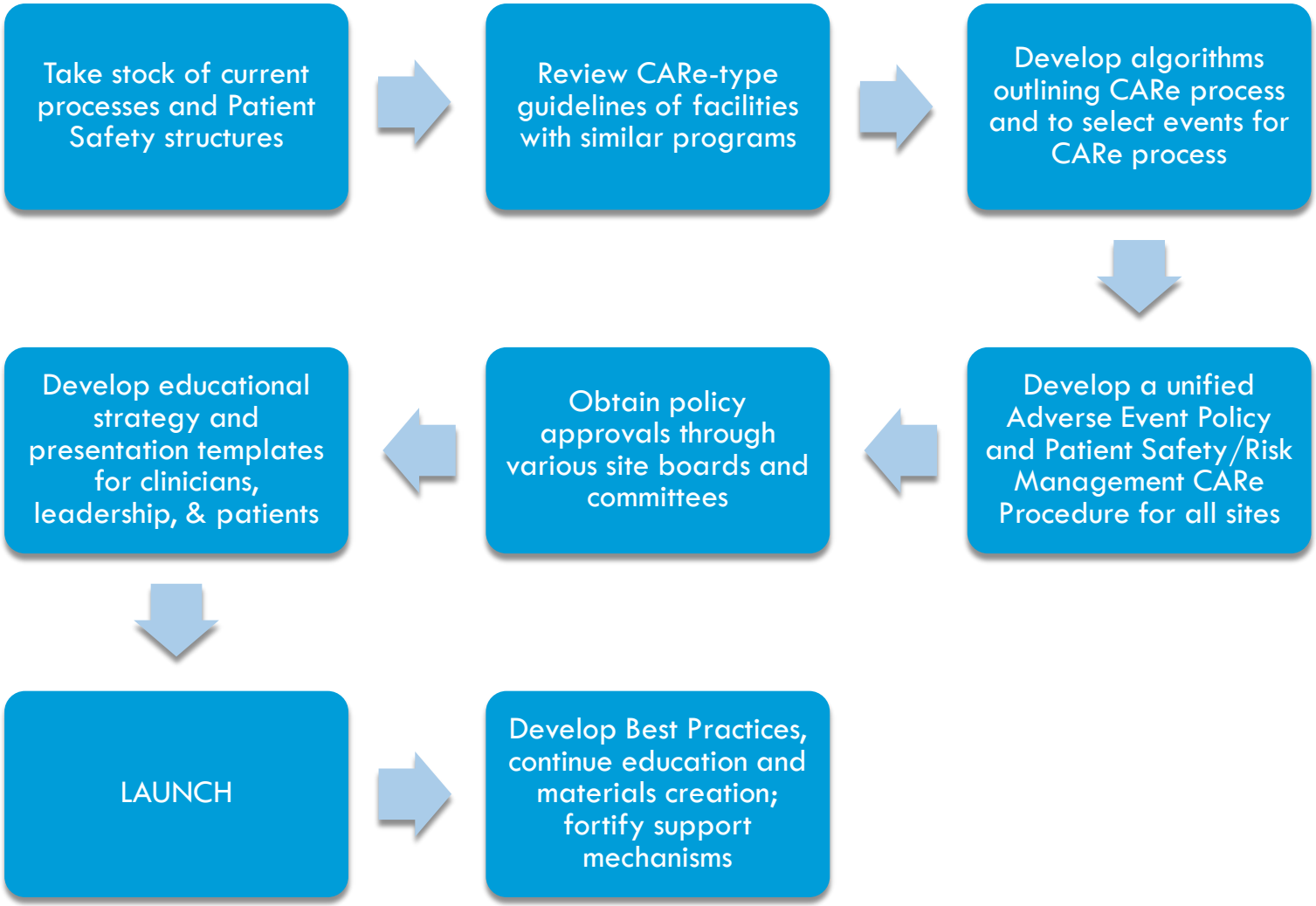
MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

Launch – Begin Assessment

Assessment Strategy (enrollment began December 1, 2012)

- 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).

A Path to CARe Implementation

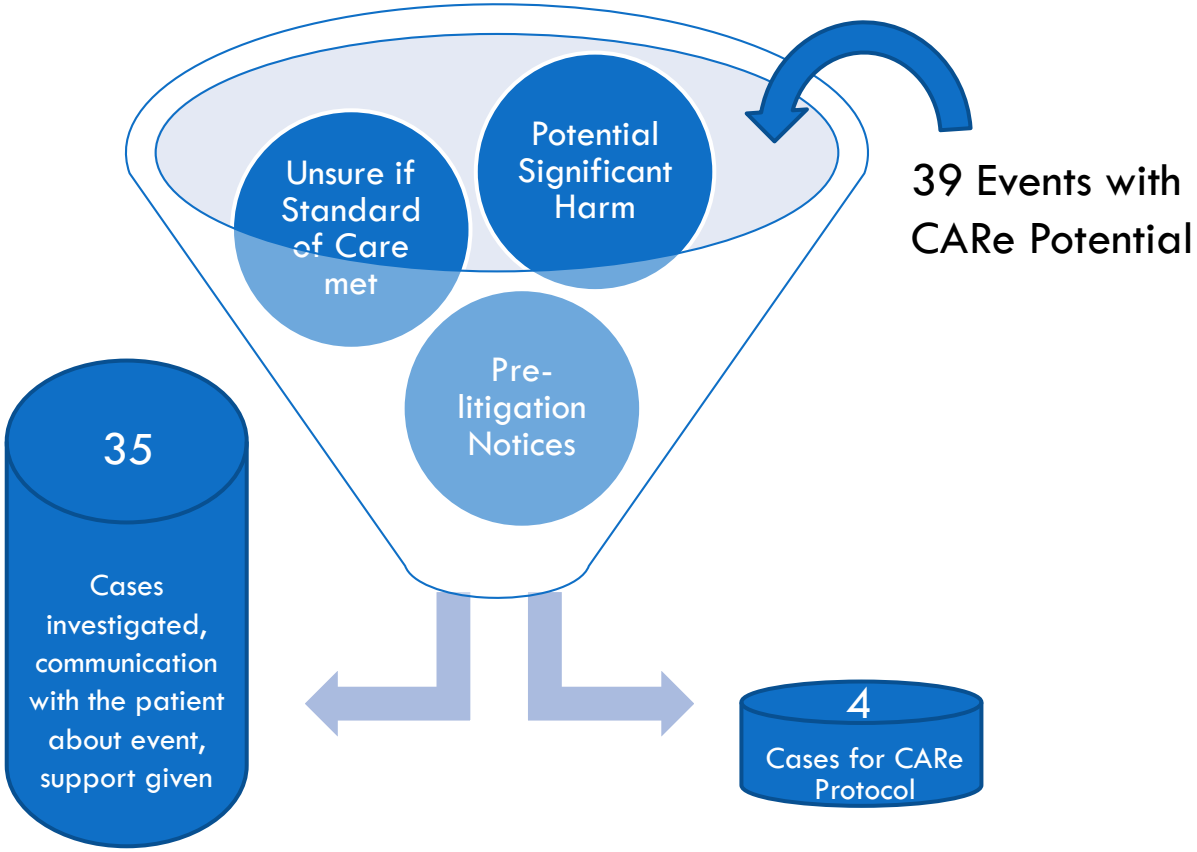


MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

The Post-Launch Phase

- Develop Best Practices
- Continue Education
- Fortify Support Mechanisms
  - Continue “just in time” support and coaching for a difficult communication (“disclosure”) in immediate aftermath of an adverse event
  - Formalize peer support / second victim programs
  - Publicize support resource list for patients and disseminate patient materials

A Picture of CARe Today



Stanford's PEARL

The Process for Early Assessment and Resolution of Loss

Jeffrey Driver, Esq.
Chief Executive Officer

STANFORD UNIVERSITY MEDICAL NETWORK | RISK AUTHORITY

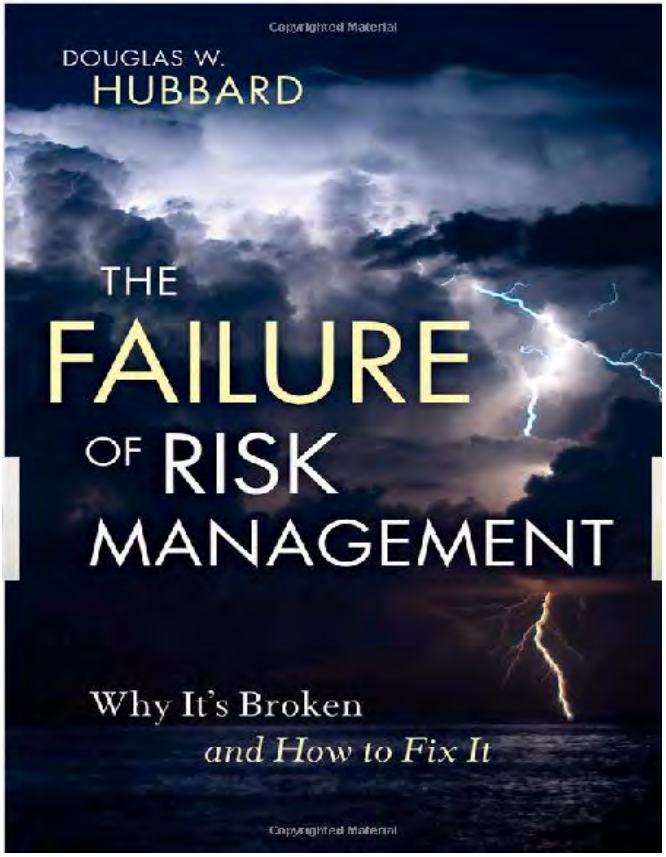
Learning Objectives

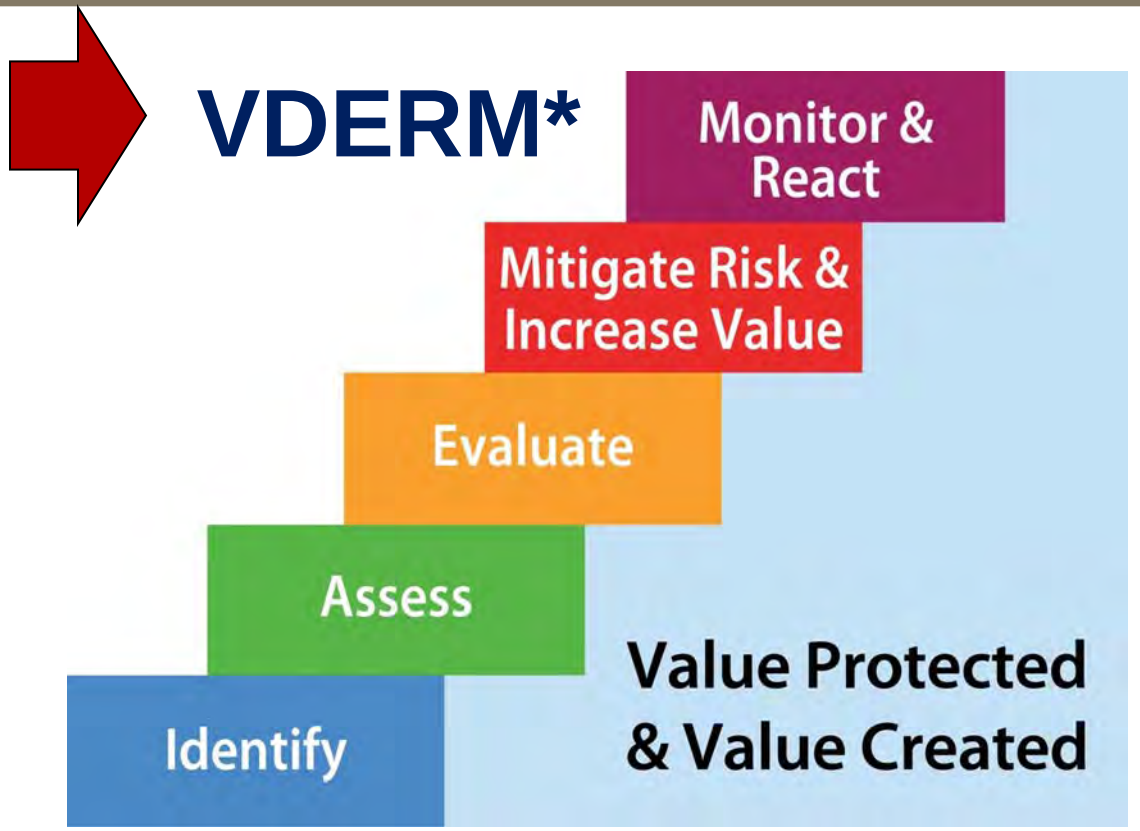
- PEARL and the History of the PEARL Program
- PEARL Program Design
- PEARL Enhancements
- PEARL Outcomes and Measures
- Impact of CMS Requirements for Medicare Beneficiary related Medical Malpractice Claims

What is PEARL?

History of the PEARL Program

PEARL is a Cornerstone of an Overarching Strategic Risk Management Practice





* VDERM = Value Driven Enterprise Risk Management
ISO 31000 + Decision Analysis Science

Stanford's Journey Into "Disclosure and Resolution"

- "Discreet and selective practice" began with in-house claims management (September 2005)
- Successes and failures analyzed
- Pioneering programs, observations, and peer reviewed research studied (VA, UM, COPIC, Harvard)
- SWOT assuming fully instituting a "full disclosure" approach
- Formal program launched along side of on-going Stanford and University of Washington research project (September 2007)
- Recent PEARL enhancements in 2012 (PEARL Patient and Family Site, Patient Advocate, Caring Conversations Simulation)

Entering a Controversial & Pioneering Space

MARKETWATCH

Disclosure Of Medical Injury To Patients: An Improbable Risk Management Strategy

Movement toward full disclosure should proceed with a realistic expectation of the financial implications and prudent planning to meet them.

by David M. Studdert, Michelle M. Mello, Atul A. Gawande, Troyen A. Brennan, and Y. Claire Wang

ABSTRACT: Pressure mounts on physicians and hospitals to disclose adverse outcomes of care to patients. Although such transparency diverges from traditional risk management strategy, recent commentary has suggested that disclosure will actually reduce providers' liability exposure. We tested this theory by modeling the litigation consequences of disclosure. We found that forecasts of reduced litigation volume or cost do not withstand close scrutiny. A policy question more pressing than whether moving toward routine disclosure will expand litigation is the question of how large such an expansion might be. [*Health Affairs 26,* no. 1 (2007): 215–226; 10.1377/hlthaff.26.1.215]

Entering a Controversial & Pioneering Space

MALPRACTICE

By Lindsey Murtagh, Thomas H. Gallagher, Penny Andrew, and Michelle M. Mello

Disclosure-And-Resolution Programs That Include Generous Compensation Offers May Prompt A Complex Patient Response

DOI: 10.1377/hlthaff.2012.0185
HEALTH AFFAIRS 31,
NO. 12 (2012): –

ABSTRACT Under "disclosure-and-resolution" programs, health systems disclose adverse events to affected patients and their families; apologize; and, where appropriate, offer compensation. Early adopters of this approach have reported reduced liability costs, but the extent to which these results stem from effective disclosure and apology practices, versus compensation offers, is unknown. Using survey vignettes, we examined the effects of different compensation offers on individuals' responses to disclosures of medical errors compared to explanation and apology alone. Our results show that although two-thirds of these individuals desired compensation offers, increasing the offer amount did not improve key outcomes. Full-compensation offers did not decrease the likelihood of seeking legal advice and increased the likelihood that people perceived the disclosure and apology as motivated by providers' desire to avoid litigation. Hospitals, physicians, and malpractice insurers should consider this complex interplay as they implement similar initiatives. They may benefit from separating disclosure conversations and compensation offers and from excluding physicians from compensation discussions.

Lindsey Murtagh is an associate at the law firm Hogan Lovells, in Washington, D.C.

Thomas H. Gallagher is a professor in the Department of Medicine and the Department of Bioethics and Humanities at the University of Washington, in Seattle.

Penny Andrew is the clinical lead for quality at the Waitemata District Health Board, in New Zealand.

Michelle M. Mello (mmello@hsph.harvard.edu) is a professor of law and public health in the Department of Health Policy and Management and director of the Program in Law and Public Health at the Harvard School of Public Health, in Boston, Massachusetts.

Overview of the Stanford Approach in the Disclosure and Resolution Space

- Once Optimistic and Cautious, now Convinced and Careful
- Heavily influenced by the Stanford research mission
- Quest to isolate and determine individual and overall *PEARL* outcomes and their success drivers
- Annual independent actuarial monitoring and outcomes studies

PEARL Program Design

How we Describe PEARL: A Hybrid Values & Claims Centric Model

- *PEARL* is values and principles based – as well as smart business practice
- *PEARL* promotes transparency, integrity, fairness, and healing
- *PEARL* is consistent with insurance company stewardship principles
- *PEARL* distinguishes between anticipated outcomes, unanticipated outcomes, and *preventable* unanticipated outcomes (PUO's)

How does *PEARL* work?

- *PEARL* provides around-the-clock telephonic consultation for "*concerning outcomes"*
- Consultation is provided by trained *"PEARL Risk & Claims Advisors"* acting within approved insurance company protocol
- *PEARL* embraces and builds upon any disclosure policy
- *PEARL* utilizes *"Just-In-Time"* expert coaching
- *PEARL* is always initially focused on *"assessment"* to determine if the medical outcome is a PUO

How does *PEARL* approach a PUO?

- Once a PUO is established, the *PEARL Risk & Claims Advisor* will coach selected spokesperson (hospital and/or physician) on:
  - Full disclosure
  - Communicating lessons learned
  - Approaching needs assessment
  - Listening

Five *PEARL* Instructions

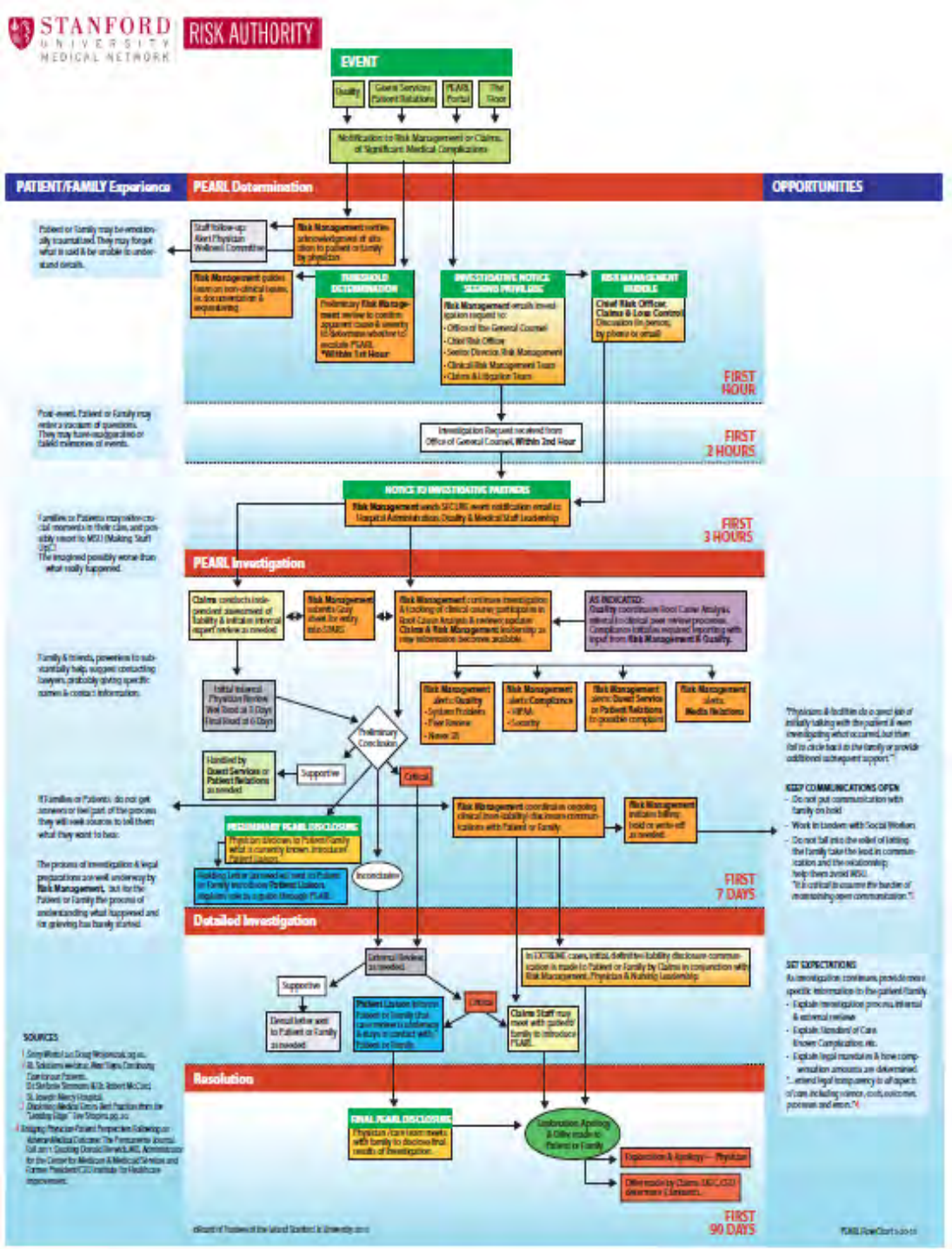
- Stabilize patient
- Take all necessary actions to promote patient safety
- Call *PEARL Risk & Claims Advisor* ASAP, but < 4 hours after PUO
- Proceed with documenting the patient's care after speaking to your *PEARL Risk & Claims Advisor*
- Record *PEARL Risk & Claims Advisor* name and phone number as exclusive contact regarding PUO, unless instructed otherwise

Three *PEARL* Cautions

- Do not jump to conclusions
- Do not blame or accuse others
- Never make promises or offer to waive bills or make offer of compensation without express approval of *PEARL Risk & Claims Advisor*

PEARL 7- Day Investigatory Process Flow

- Threshold Determination
- Investigative Notice
- Risk Management Huddle
- Notice to Investigative Partners
- Concurrent Quality, Risk and Claims Investigation
- 3-Day "Wet-Read"
- 6-Day "Final-Read"
- Pearl Conclusion and Follow-up

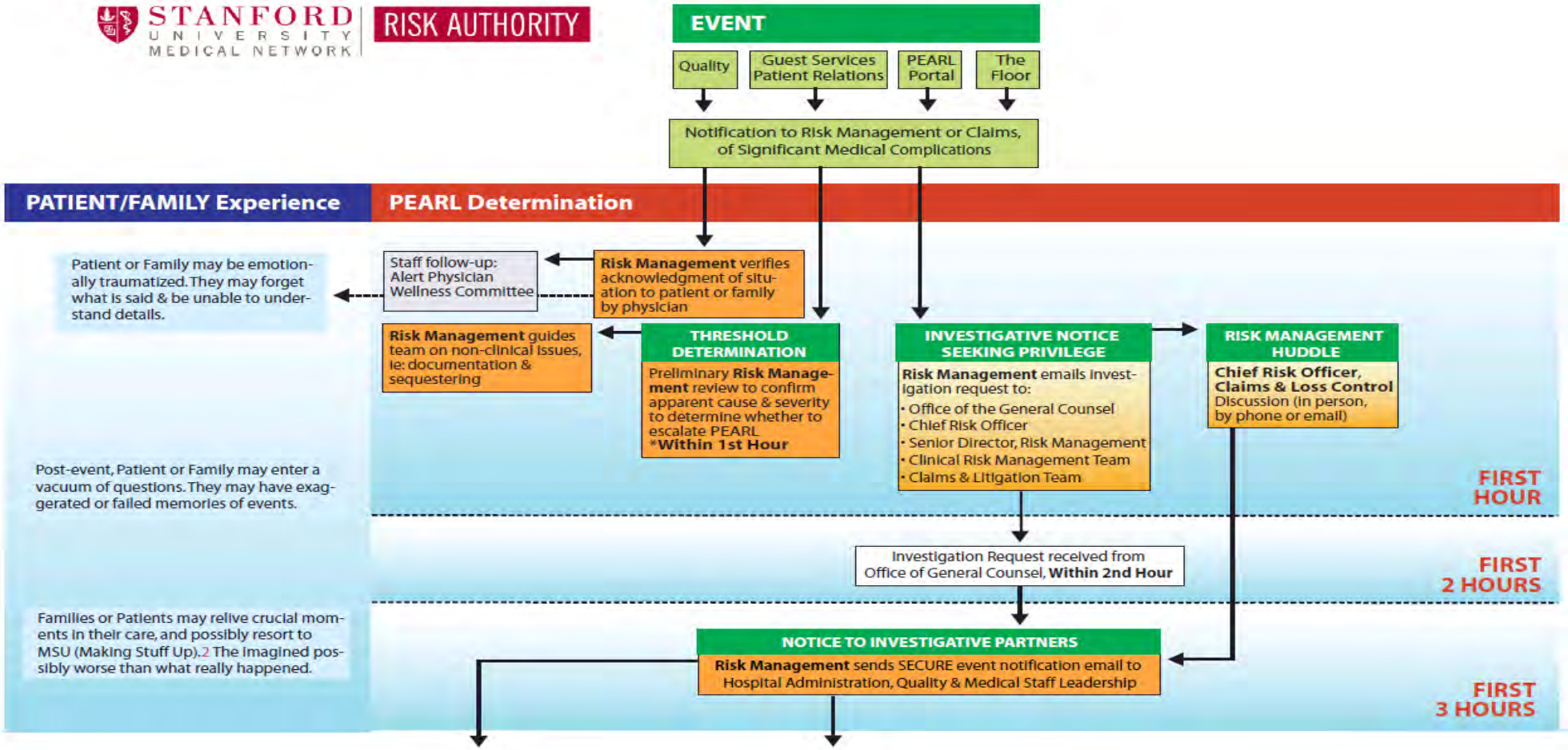


Stanford's *PEARL*

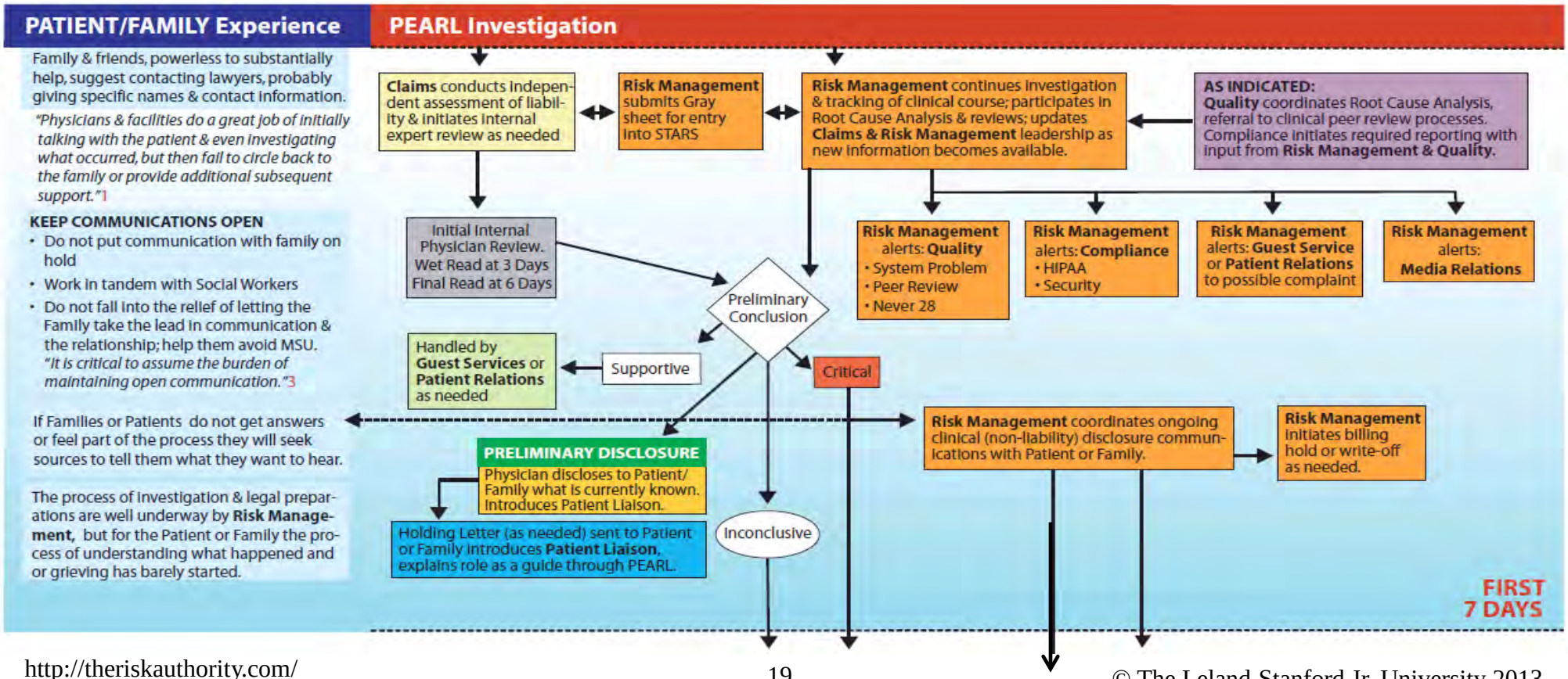
PEARL Process

To receive a copy of the PEARL process diagram, please contact:
riskmanagement@stanfordmed.org

The *PEARL* Process

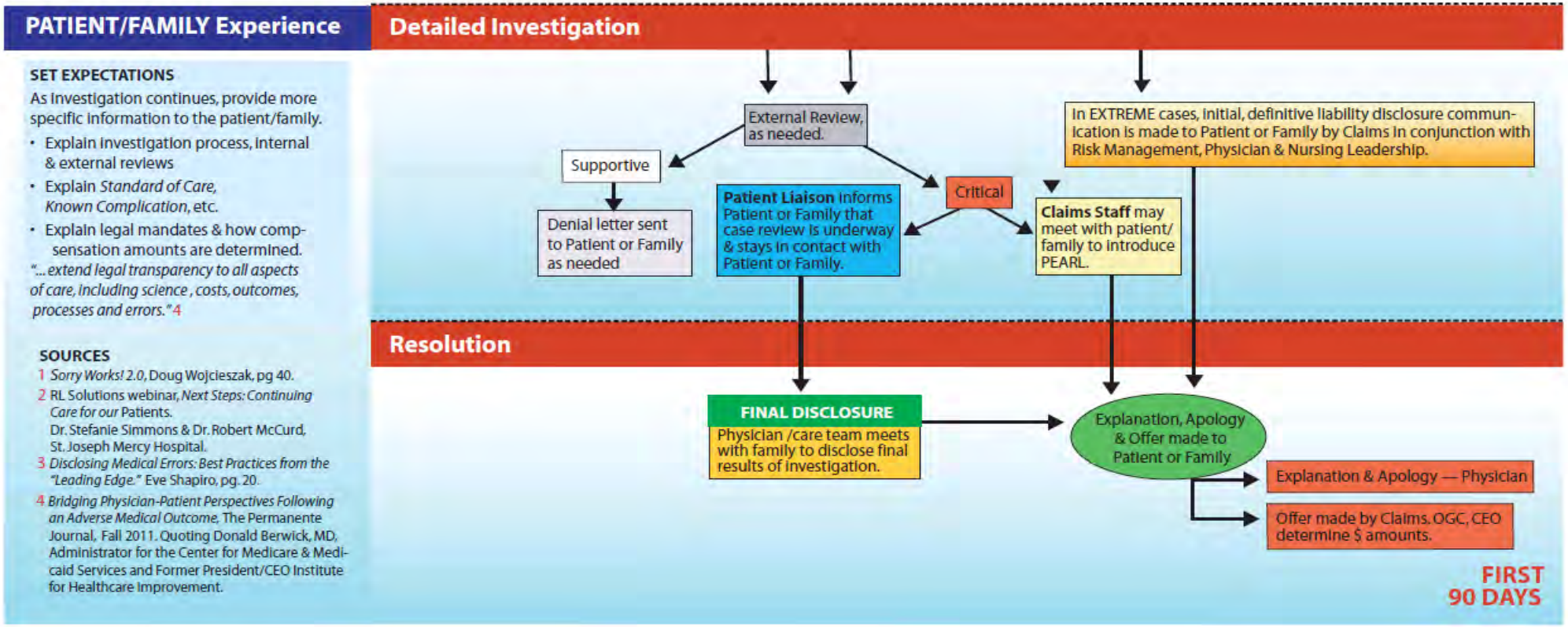


The *PEARL* Process



The *PEARL* Process

STANFORD UNIVERSITY MEDICAL NETWORK | RISK AUTHORITY



How does *PEARL* approach a settlement offer?

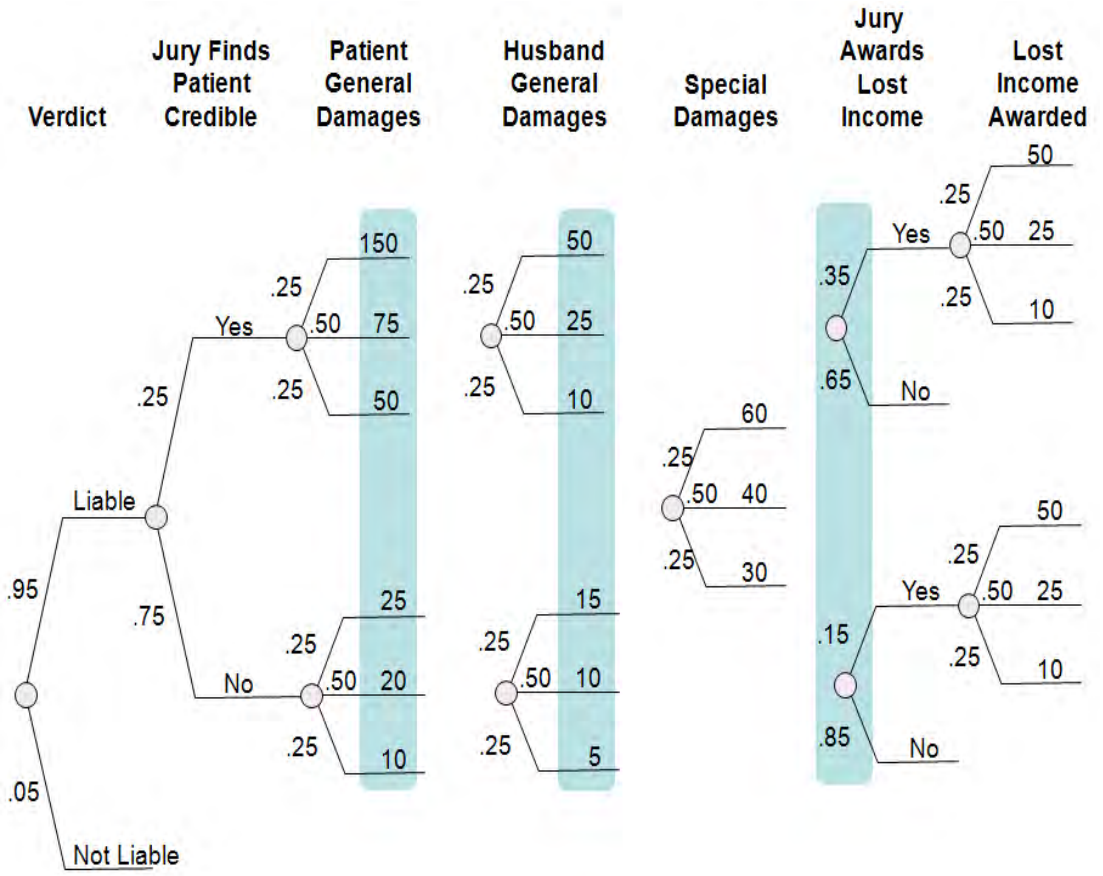
- Once a family needs assessment is done, the *PEARL Risk & Claims Advisor* will authorize an early offer for discussion with patient and/or family
  - Offers are based on needs assessment
  - Offers are up to full indemnity reserve valuation*
  - Settlement agreement required and use of counsel encouraged
  - Minors compromise is sought (California)
  - *Sponsored* mediation on case-by-case basis

***Utilizing DART Process**

Decision Analysis Reserve Targeting

Provides a theoretically sound, proven, systematic, transparent and defensible process for setting loss reserves which fully considers the uncertainty inherent in each case and which makes full use of experience and judgment.

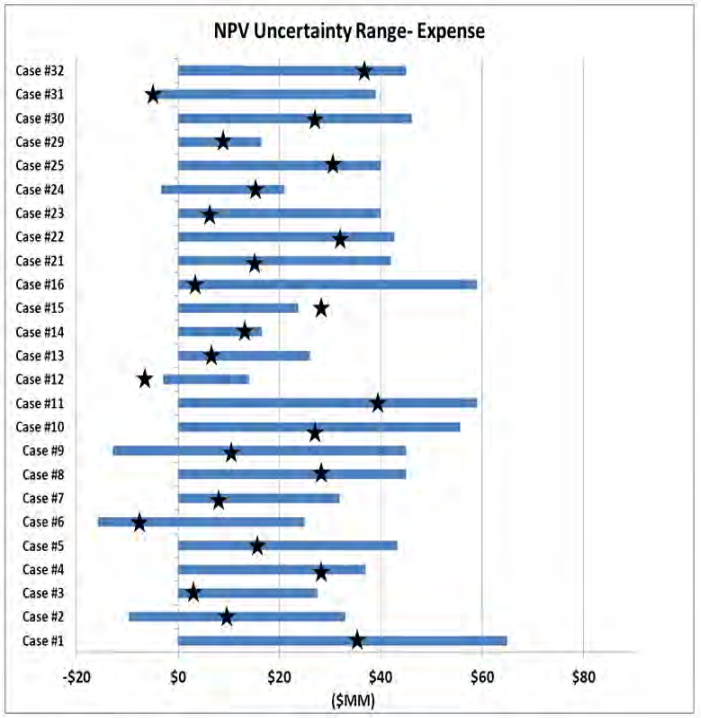
Decision Analysis Reserve Targeting

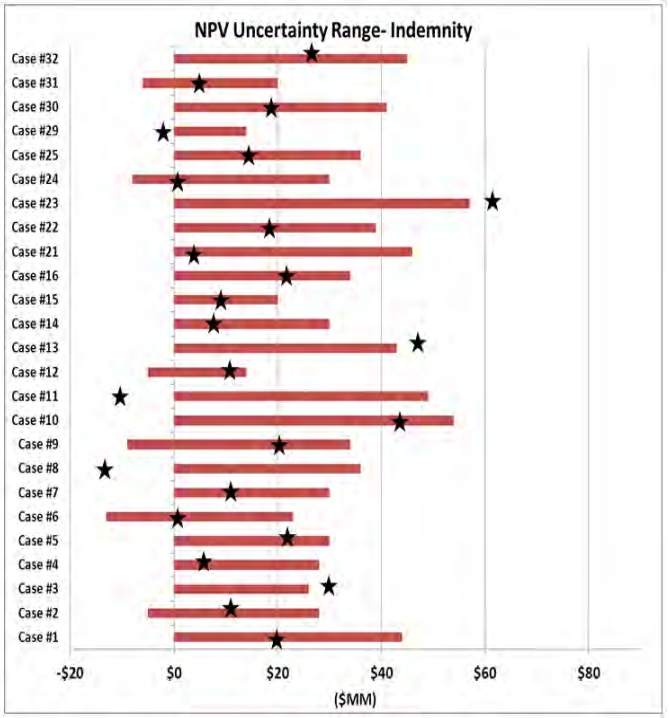


DART applies to all PEARL cases and high-value cases where the amount of indemnity and expense reserves are over $25,000

Decision Analysis Reserve Targeting

"Forecasted vs. Actual" Total Incurred Values





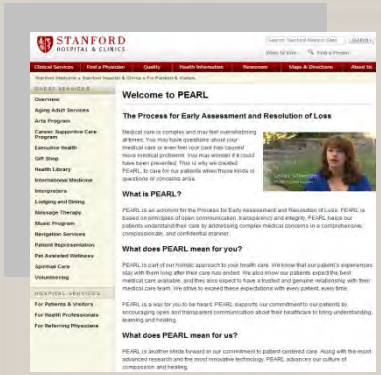
Provides a means of evaluating process validity and quality and assuring both on an ongoing basis.

< Not actual data
For illustration only

PEARL Enhancements

Stanford's PEARL Patient and Family Portal

Website

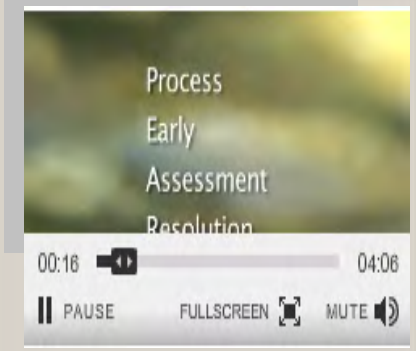


OVERVIEW AND DESCRIPTION OF PEARL PROCESS

WHAT PATIENTS CAN EXPECT

HOW TO ACCESS PEARL

Video



2 MINUTE HIGH-LEVEL OVERVIEW OF PEARL AND HOW TO ACCESS

FEATURES PATIENT LIAISON

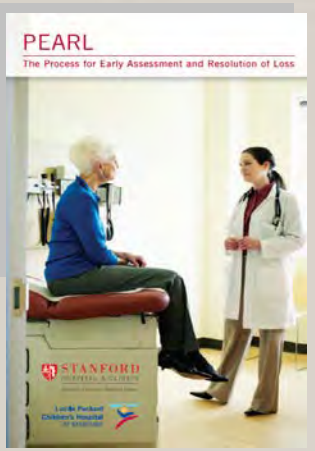
CONNECTS PEARL TO HOSPITAL MISSION AND VISION

Assessment

ASSESSMENT HELPS PATIENTS DETERMINE IF THEIR CONCERN IS A PEARL

IF NOT A PEARL, PATIENTS ARE REFERRED TO GUEST SERVICES FOR TIMELY RESPONSE

Brochure



DESIGNED FOR PATIENTS AND THEIR FAMILIES

SUMMARIZES THE PEARL PROCESS

DESCRIBES HOW PATIENTS CAN ACCESS

Emerging PEARL Communication Model

Risk Management Claims Team

Risk Management/Claims investigates possible liability.

- *Risk/Claims keeps PA informed of investigation as relevant to patient.*
- *Answers questions from Patient.*
- *Makes final recommendation after conclusion of investogation.*

PEARL Patient Advocate

Patient Advocate is intermediary between Patient or Family & Risk Management.

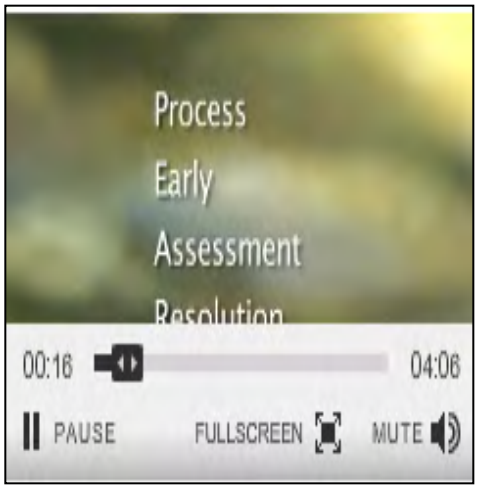
- *In consistent contact with Patient, explaining PEARL process & setting expectations.*
- *All questions/concerns are relayed to Risk/Claims Team.*
- *PA is in consistent contact with Risk/Claims regarding status of investigation and mindset of Patient or Family.*
- *When necessary PA, introduces Patient to Risk/Claims.*

Patient or Family

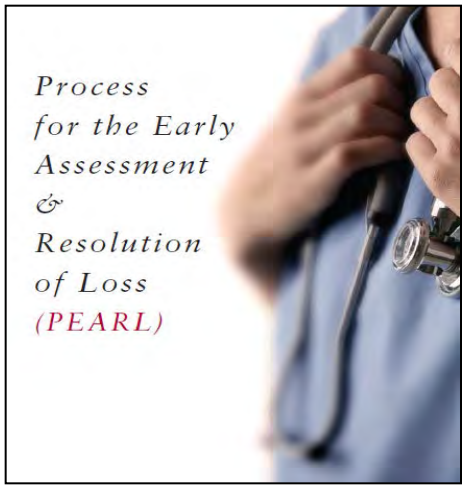
Patient or Family may become part of PEARL after experiencing an unexpected event in their care.

- *Patient is introduced to PEARL by PA.*
- *Contact information for PA is given to Patient.*
- *PA is Patient's direct contact for questions/concerns about PEARL.*

PEARL Patient and Provider Education

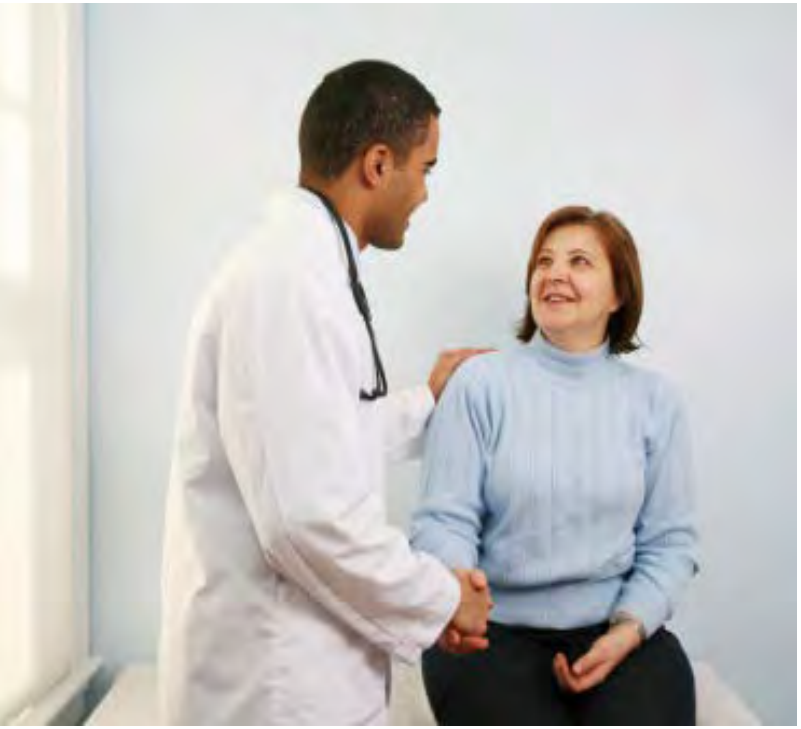


PEARL Patient and Family Video



PEARL Physician Education Video

Caring Conversations Simulation Project



What is the best way to communicate with patients and families after determining a PEARL result?

How can we build an atmosphere of trust with patients after a disclosure?

Caring Conversations Simulation Project

Goal:

To develop a framework of successful methods for approaching post-disclosure conversations with patients & families through use of fully developed & tested simulations.

Process:

Use actors and scenarios to 'play-out' after disclosure discussions with patients & families to find the responses that are most helpful.

Two Scenarios:

- Medication allergy procedure is not followed
- Medication allergy is not anticipated

Simulation Video

PEARL Outcomes and Measures

15+1 PEARL Outcomes Measures

- Expenses paid
- Indemnity paid
- Case reserves
- Comparison of Paid v. Reserved
- Pending lawsuits
- Case open time
- Physician well-being
- Patient satisfaction/distress
- Physician satisfaction/distress
- SUMIT staff satisfaction
- Patient forgiveness
- Time of report/recognition
- Report to NPDB & CMB
- Corporate morale/Culture
- Resolution method

PEARL Results

Metric	Desired Result	Observed Result	Comment
Reporting Pattern	Faster	Unchanged	Average incident to report lag is one year
Frequency	Lower	Lower	Annual reported claims dropped from 23 to 15
Closing Pattern	Faster	Inconclusive	Small number of closed claims
Severity	Lower	Inconclusive	Some large post-PEARL closed claims
Overall Cost	Lower	Lower	**38% reduction over 5 years**

Milliman

* Reinvestments in Loss Control Programs vs. Premium Rebates and Holidays

Lessons Learned

- Prompt evaluation of patient concerns and appropriate intervention is critical
- Education and training is an important component to *PEARL* success
- Information is power
- Early investigations pay dividends in warding off and defending claims, as well as reducing claims expenses

New CMS Requirements for Medicare beneficiary related medical malpractice claims

Impact of New CMS Requirements on Disclosure and Resolution Programs

- MMSEA does not change the underlying and already existing responsibility of the patient to pay for any outstanding medical liens at the time of settlement of a claim
- CMS continues to modify their rules, but as written MMSEA only requires the settling party to give formal notice of the settlement
- Current release language should always include a paragraph that states that the patient has sole responsibility for satisfying any liens that may exist, medical or otherwise, whether known or unknown
- Consider including a sentence in settlement releases that informs the plaintiff of MMSEA reporting and reiterate the fact that the patient will have the sole responsibility to satisfy any liens that may exist, now or in the future

Impact of New CMS Requirements on Disclosure and Resolution Programs

- Anticipate plaintiffs being much tougher to settle, unless the hospital agrees to pay a specific amount in settlements that represents the value of the medical lien Plaintiffs already make this argument, but the settling parties rarely respond to such, in part due to the fact that we all know historically that the liens have not been enforced, or have been significantly discounted

- If Medicare becomes more serious about enforcing liens, anticipate plaintiffs to become more serious about refusing a settlement that does not satisfy the amount of the lien

Tracking Our Progress

To stay current on PEARL's progress and find public information, visit our website at:

http://theriskauthority/resources/

Stanford's PEARL

The Process for Early Assessment and Resolution of Loss

Jeffrey Driver, Esq.
Chief Executive Officer

STANFORD UNIVERSITY MEDICAL NETWORK | RISK AUTHORITY