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Partnering with a med-mal insurer to improve care, cut costs

By Larry Smith and Nat Cross

The popular stereotype of the role played by medical malpractice insurers in the nation's healthcare system is not positive. And it's true that hospitals and their insurers can be wary and contentious partners, tied together by financial necessity and the stark realities of a litigious society. But it doesn't need to be that way.

The biggest beneficiaries of a seven-year relationship between MedStar Health, a $4.5 billion, not-for-profit healthcare system in the Washington area, and Beazley, a Lloyd's of London insurer, have been MedStar's patients.

Our association began amid a transformation of the American healthcare delivery system triggered by the 1999 Institute of Medicine report "To Err is Human," declaring that between 50,000 and 100,000 deaths occur in American hospitals each year from preventable medical errors. For MedStar, addressing the problem meant a willingness to embrace new technology and "human factor solutions." In time it led to MedStar building a state-of-the-art National Center for Human Factors in Healthcare, the largest such engineering program within the healthcare system in the U.S.

For Beazley, the challenge was to find a way to reward hospitals for taking steps to improve the quality and safety of patient care before claims came to fruition, a process that can take up to 10 years. The result was a program that rewards hospitals that implement a pre-agreed set of quality and safety measures with a reimbursement of 5% to 10% of the premium, regardless of their ultimate claims experience. The logic is simple: Hospitals that provide the highest quality care will, over time, have lower claims.

Most of the incentive programs in today's medical malpractice market do not work this way. They are more mechanistic and are based on awards for past performance from outside agencies. Beazley wanted to encourage clients to look forward and proactively embrace a significant change in mindset about safety and human error.

Smith *Cross*

Because more than 50% of the malpractice claims Beazley sees relate to birthing errors, MedStar and Beazley initially focused on obstetrics. In our initial conversations, MedStar demonstrated an electronic health-record system designed exclusively for obstetrical care by an Israeli obstetrician who was tired of seeing the same kinds of preventable injuries occurring at the time of birth. The system runs algorithms that predict when the fetus is likely to suffer distress and alerts clinicians before trouble begins. Technologies can reduce the possibility of human error in a busy obstetrical unit with many patients and numerous opportunities for a clinician to be distracted.

Advanced technology can improve safety and quality, but the right training is also essential. To that end, MedStar built the Simulation Training & Education Labs in Washington and Baltimore where physicians, nurses and staff are exposed to clinical simulation training using the most advanced equipment and working with an interdisciplinary team of clinical educators, instructional designers, software developers, simulation technologists and—perhaps surprisingly—artists who develop education and training solutions.

Beazley's encouragement and financial support helped pave the way for operational and cultural changes in MedStar's obstetrical services and we have seen a significant decrease in the frequency and severity of obstetrical liability claims.

A more recent area of focus has been diagnostic errors. Much depends on the initial diagnosis, especially in emergencies. For example, if a furniture mover comes to the emergency room complaining of severe back pain, and an exam and the blood tests show nothing unusual, the presumption might be that the patient strained his back while working. But there is also a chance that the problem is spinal cord compression resulting in an extremely dangerous spinal abscess. It is a rare situation but it has happened.

Between 2001 and 2011, MedStar had 22 claims where injury from spinal cord compression was the principal cause. The resulting claims cost MedStar more than $30 million in indemnity payouts and another $5 million in legal expenses. In 2012, a Web-based learning program was implemented to help clinical staff recognize and treat spinal cord compression in the ER. A specific spinal cord diagnostic algorithm was also developed to help clinicians identify the problem correctly. Since then, no back patient at MedStar has been misdiagnosed in this manner.

This sort of collaboration should be widely reproducible across the healthcare system. A close partnership with a like-minded insurer can be particularly valuable for a hospital system in guarding against very low frequency—but potentially very severe—risks. An insurer active in this market for a decade or more will normally have access to a far deeper pool of experience than any one hospital.

With the recent consolidation of major healthcare providers around the country and increased efforts to bring soaring medical costs under control, this is an environment where collaboration needs to be embraced. Since the 1999 Institute of Medicine report, millions of words have been written about the challenge of achieving meaningful reductions in what are blandly called "preventable adverse events" in hospitals. MedStar's experience suggests that the support of a seasoned med-mal insurer could play a bigger role.

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