MPL MEDICAL PROFESSIONAL LIABILITY ASSOCIATION

2021 MPL ASSOCIATION CONFERENCE

Improving Quality through Value-based Care

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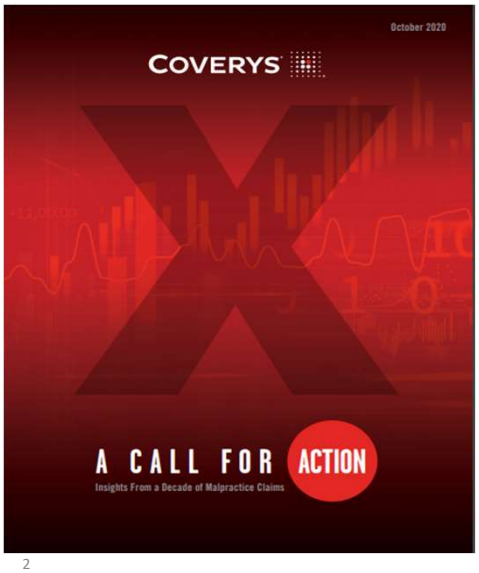

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Coverys:

"A Call for Action", produced in Oct. 2020

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We often describe malpractice claims as the "tip of the iceberg"…

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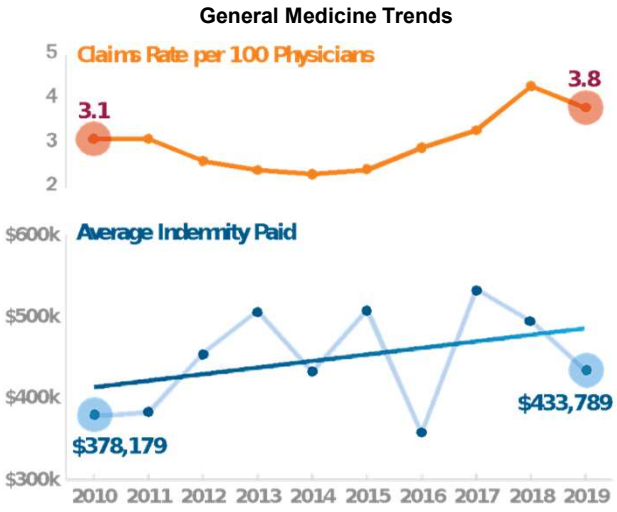
General Medicine (2010-2019)



Claims Rate: N = 9,935 physicians between 2010-2019.
Indemnity: N = 586 closed claims with indemnity paid between 2010-2019.

- The rate of claims for general medicine has ***trended upward*** in recent years
- One of the primary contributors to this is ***diagnostic error***, which has shown virtually no improvement over the last decade

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Surgery (2010-2019)

Cla Claims Rate: N = 26,279 physicians between 2010-2019.
Ind Indemnity: N = 3,485 claims closed with indemnity paid between 2010-2019.

- The rate of claims per 100 surgeons is on a downward trend, with an average of 12.4 claims per 100 physicians during 2010-2014, lowered to 9.7 from 2015 to 2019
- Improvements are noted in claims involving wrong-site surgery and retained objects
- "Technical performance" [skill-based] issues ***have shown minimal improvement*** over the past decade

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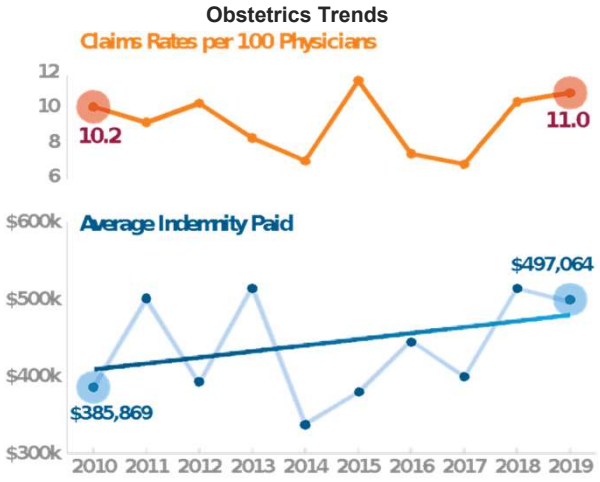
Obstetrics (2010-2019)



Claims Rate: N = 2,797 physicians between 2010-2019.
Indemnity: N = 1,207 claims closed with indemnity paid between 2010-2019.

- Claims frequency in obstetrical cases ***increased slightly*** from an average of 9.1 claims per 100 physicians, 2010-2014, to 9.5 claims per 100 physicians, 2015-2019
- The rate of claims with indemnity paid was 32%, significantly higher than other types of claims
- The L&D phase of care continues to be problematic, but pre-natal management issues ***have increased*** over the last 10 years

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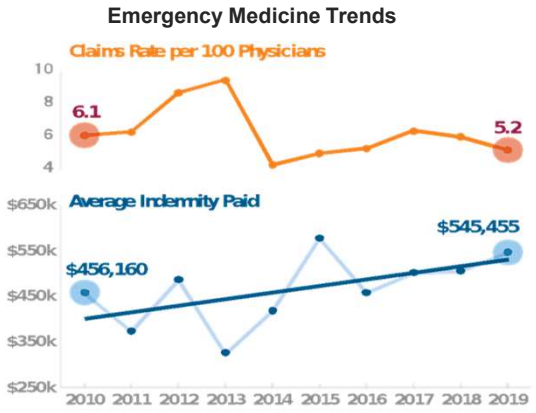
Emergency Medicine (2010-2019)



- The rate of claims for emergency medicine appears to be declining
- Missed or delayed diagnosis ***continues to be the dominant issue*** in emergency medicine claims (53%), significantly higher than other issues such as medication error (10%).

Claims Rate: N = 12,157 physicians between 2010-2019.
Indemnity: N = 1,064 closed claims with indemnity paid between 2010-2019.

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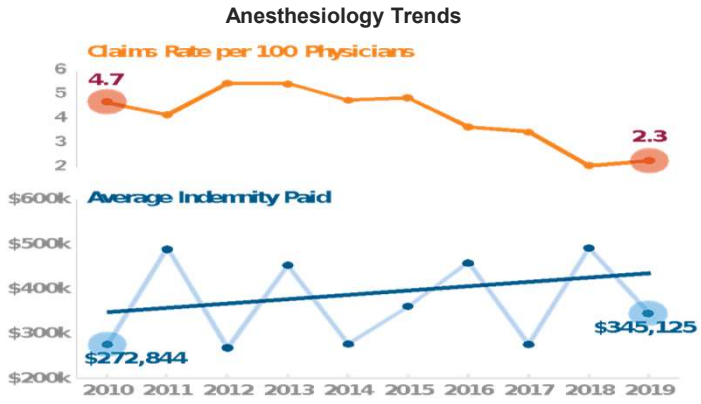
Anesthesiology (2010-2019)



- Through the lens of malpractice, anesthesia is a ***success story***
- The overall claims rate ***reduced significantly*** from 4.7 claims per 100 physicians, 2010-2014, to 2.3 per 100, 2015-2019
- The practice of anesthesia now highly data driven, with a focus on simulation training, crisis management, and evidence-based decision making

Claims Rate: N = 9,935 physicians between 2010-2019.
Indemnity: N = 586 closed claims with indemnity paid between 2010-2019.

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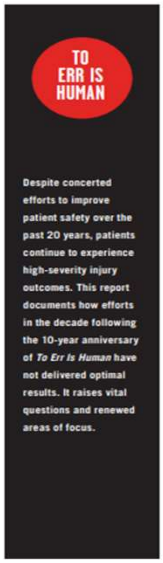
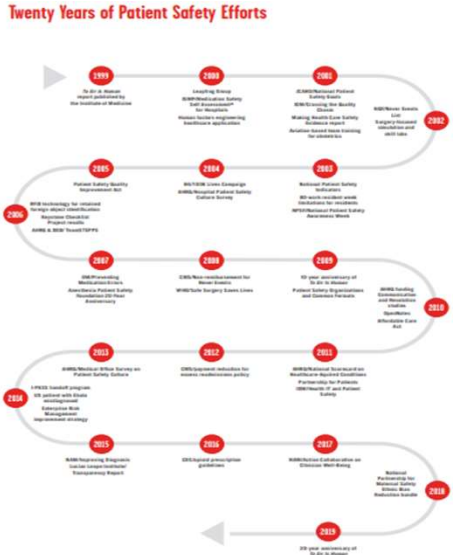
In 1999, the groundbreaking IOM report was released…





… shocking the public and spurring a multitude of patient safety initiatives…

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"Big Data" for healthcare looks like this…

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Missing: "Central Intel" for healthcare

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A "Divining Rod" for Patient Safety…

Malpractice Data

- Deeply analyzed cases -- particularly valuable if causation factors can be aggregated
- Provides important "signal data" that can guide what to look for in present-day setting
- Has dollars associated with it

Limitations:

- Always a look to the past
- Small numbers raise question of statistical significance
- Unique convergences of factors don't generally repeat themselves in exactly the same way

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The movement to value-based care

- Through the lens of malpractice…
  - Do we understand it?
  - Are we ready for it?
  - Will it require us to think about risk in a different way?
  - What can we do now to better position ourselves?

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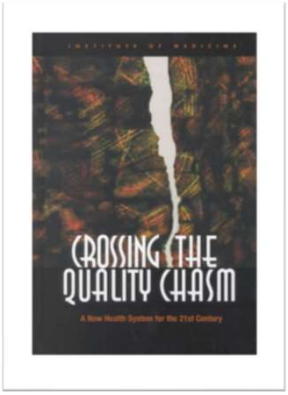
MCIC
VERMONT
A Reciprocal Risk Retention Group

Value and Healthcare Equity

Ron Wyatt, MD MHA
Vice-President and Patient Safety Officer

Crossing the Quality Chasm - Six Aims for Improvement

- Safety
- Timeliness
- Effectiveness
- Efficiency
- Equity
- Patient-Centeredness



IOM Crossing the Quality Chasm: A New Health System for the 21st Century, 2001

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Definitions

Health equity: Health differences "which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. When there is equity in health, "ideally everyone should have a **fair** opportunity to attain their full health potential and, more pragmatically, no one should be disadvantaged from achieving this potential, if it can be avoided." (WHO)

Health disparity and health inequity: Health disparity is defined as the difference in health outcomes between groups within a population.

- Health disparity denotes differences, whether unjust or not.
- **"Health inequity," denotes differences in health outcomes that are systematic, avoidable, and unjust.**

Health care disparity: "racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention." (IOM)

Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

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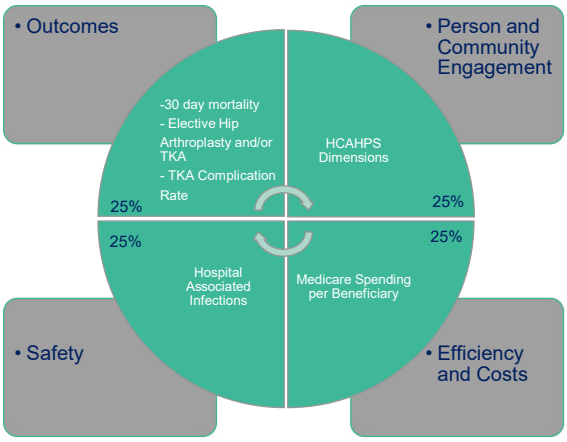
FY 2021 Hospital Vale-Based Purchasing Guide



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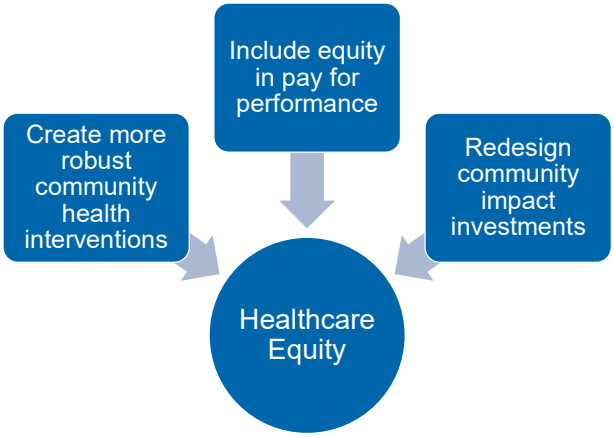
Alternative Payment Models and Equity

1. Mixed success in improving disparities.
2. Disparity is not explicit stated as a goal.
3. Can be punitive for care of socially high-risk people.
4. Black people are underrepresented in accountable care organizations.

Pathways for Value-Based Care and Health Equity



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Medical Liability System Design

1. Promotes quality in vulnerable communities;
2. Be oriented toward building trust;
3. Sharing information, facilitating timely redress of errors, anticipating;
4. Preventing injuries associated with unmet social needs;
5. Ensuring that concerns about malpractice liability do not adversely affect access to care.

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Strategies for monitoring quality of care for socially at-risk beneficiaries and providing incentives to reduce disparities

Strategy	Considerations
Measure and report quality of care for at-risk beneficiaries with social risks	Develop equity measures Begin reporting on care of at-risk beneficiaries Prospectively monitor program impact on providers who disproportionately serve at risk social populations
Set high, fair quality standards for all beneficiaries	Develop measures for adjustments on a case-by-case basis Improve risk adjustment for health status program measures
Reward and support better outcomes for high risk beneficiaries with social risk factors	Reward achievement or improvement of outcomes Use existing or new QI programs to support providers that serve such beneficiaries Increase research on the costs of caring for such beneficiaries

n engl j med 376;6 nejm.org February 9, 2017

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Malpractice Liability and Quality of Care

"As understanding broadens of how medical care relates to health, a parallel construct of health justice is emerging that examines clinical care through the lens of social equity.

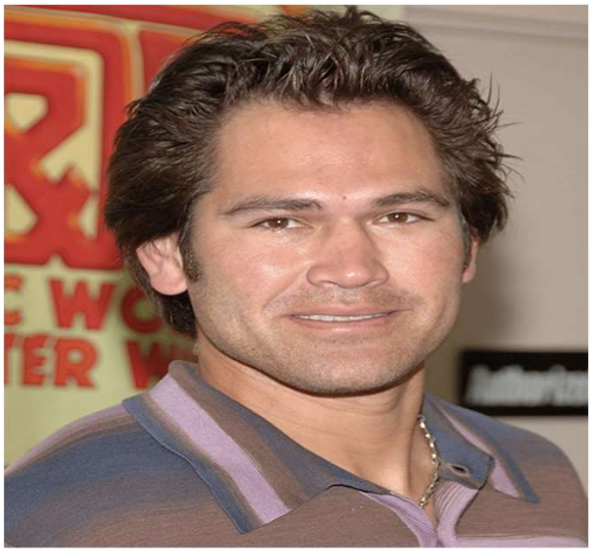
Applying health justice principles to medical liability could offer a new path to both quality and access that runs not through courtrooms and state legislatures,
but through professionalism"

JAMA January 28, 2020 Volume 323, Number 4

Archway Health

A Value Based Care Company

Spring 2021



DRAFTKINGS DAILY FANTASY

Lobby Lineups Contests Leagues Missions Promos

CROWNS 0

Season	Team	Lg	G	AB	R	H	TB	2B	3B	HR	RBI	BB	IBB	SO	SB	CS	AVG	OBP	SLG	OPS	GO/AO
1995	KC	AL	47	188	32	53	83	11	5	3	23	12	0	22	7	0	.282	.324	.441	.765	-.--
1996	KC	AL	145	517	61	140	190	22	5	6	50	31	3	64	25	5	.271	.313	.368	.680	-.--
1997	KC	AL	146	472	70	130	182	12	8	8	48	42	2	70	16	10	.275	.338	.386	.723	-.--
1998	KC	AL	161	642	104	178	282	30	10	18	66	58	4	84	26	12	.277	.339	.439	.779	-.--
1999	KC	AL	145	583	101	179	278	39	9	14	77	67	5	50	36	6	.307	.379	.477	.856	0.99
2000	KC	AL	159	655	136	214	324	42	10	16	88	65	4	60	46	9	.327	.382	.495	.877	1.02
2001	OAK	AL	155	644	108	165	234	34	4	9	49	61	1	70	27	12	.256	.324	.363	.687	0.92
2002	BOS	AL	154	623	118	178	276	34	11	14	63	65	5	70	31	6	.286	.356	.443	.799	1.01
2003	BOS	AL	145	608	103	166	246	32	6	12	67	68	4	74	30	6	.273	.345	.405	.750	1.07
2004	BOS	AL	150	621	123	189	296	35	6	20	94	76	1	71	19	8	.304	.380	.477	.857	1.18

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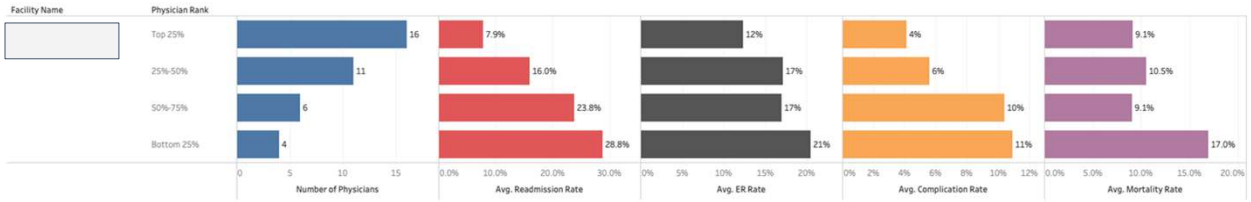
Physician Rankings - CHF

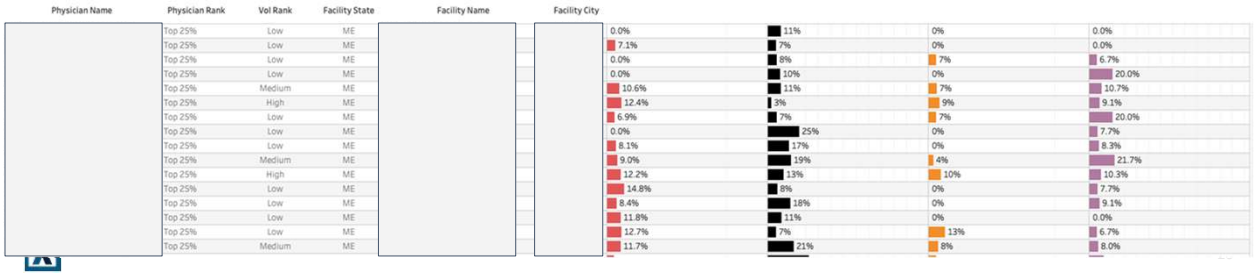
CONFIDENTIAL

Summary Quality Indicators by Physician Ranking



Physician Bundle Ranking

Bundle Type: All Bundle Name: Congestive heart failure Surgery Type: All Payer: Medicare



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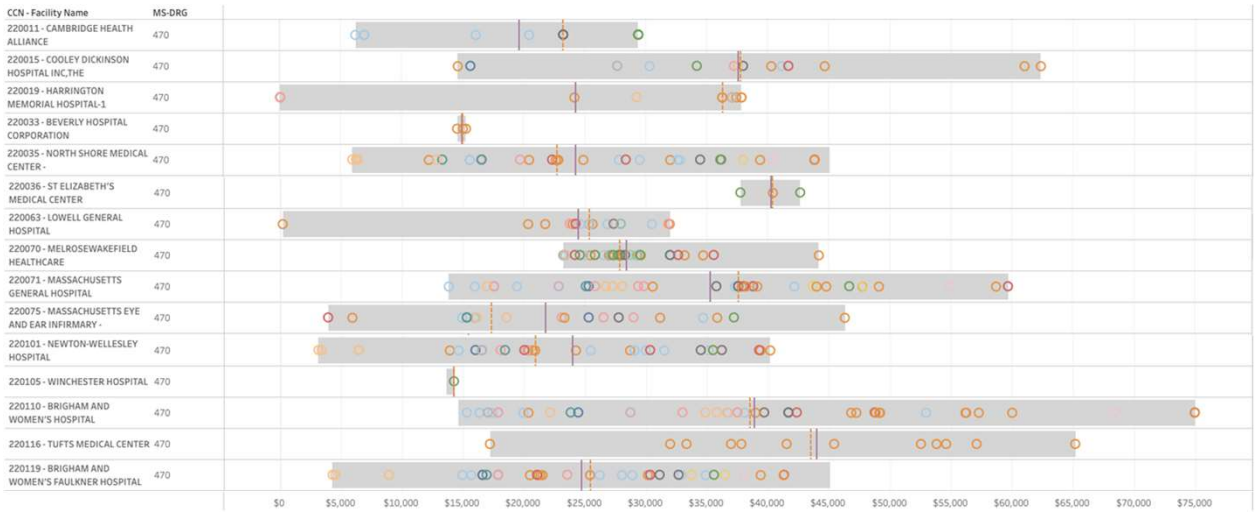
Price Variability



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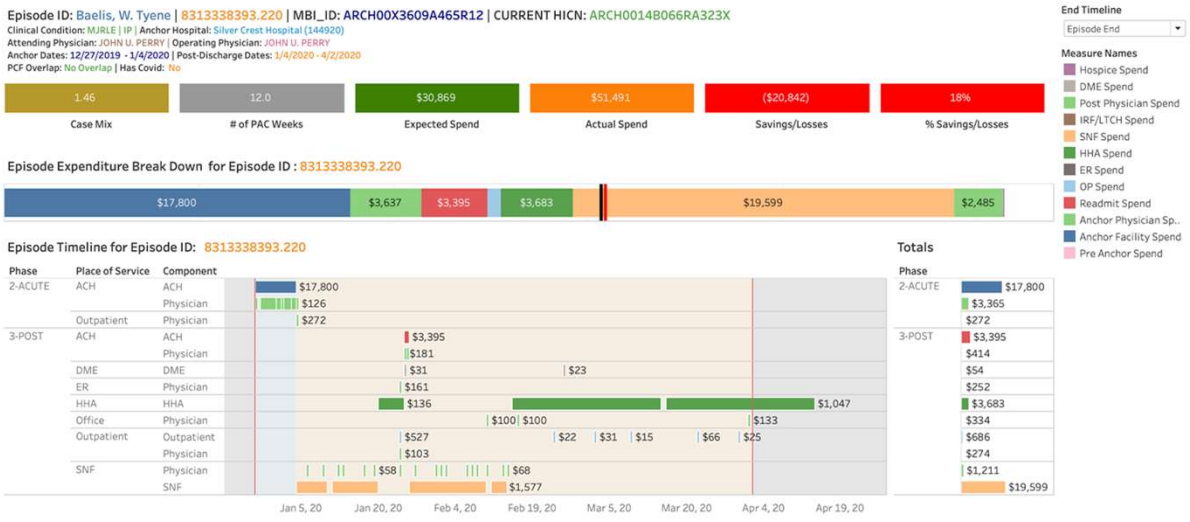
Episodic Focus



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Best Boston Area Knee Replacement Surgeons

About this list

Our mission is to guide people to high quality care based on data and analytics. This is a select list of physicians who received an "A" Quality Grade and "A" Volume Grade for Knee Replacement in the Boston Area. Archie does not receive payments from physicians and we do not accept advertising. Please email us at info@archiehealth.com if you have follow up questions.

SURGEON NAME	HOSPITAL	CONTACT	QUALITY GRADE	VOLUME GRADE	HEALTHGRADES REVIEWS	EST. WAIT FOR APPOINTMENT
Dr. JB	NEB	(617) 555--5901	A	A	3.9/5.0 48 ratings	Call Physician Office
Dr. CT	NEB	(617) 555-5474	A	A	4.3/5.0 66 ratings	2-3 Weeks
Dr. GV	GSI	(617) 555-1205	A	A	4.3/5.0 48 ratings	1-2 Weeks
Dr. JN	SE	(617) 555-1205	A	A	4.3/5.0 48 ratings	6-7 Weeks
Dr. VS	BF	(617) 555-5322	A	A	4.5/5.0 40 ratings	2 Weeks
Dr. JP	NEB	(617) 555-7111	A	A	4.7/5.0 39 ratings	2-3 Weeks

Knee Replacement Quality Report

Dr. GF
Orthopaedics

Medical License Status:
License is active in the state of Massachusetts

Board Certification:
Board certified in Orthopaedics

Federal Sanctions or Exclusions:
No federal sanctions or exclusions.

QUALITY GRADE*

Grade **A** *Provider*

Dr. GF is ranked in the top 25% percentile of physicians in Massachusetts based on our analysis.

Archie compares physicians on a state by state basis, using a proprietary methodology that incorporates measures such as complication rates, how many patients had to visit the ER after their procedure, how many were readmitted, and other measures. We also take into consideration the medical complexity of the patients that a physician treats.

VOLUME GRADE*

GRADE **A** *Provider*

Dr. Van Flandern performs more Knee Replacement surgeries than 98% of the Knee Replacement surgeons in Massachusetts. Research shows that physicians who perform high volumes of a specific procedure achieve better outcomes.

ATIENT RATINGS

4.3/5.0 *Based on 48 ratings*

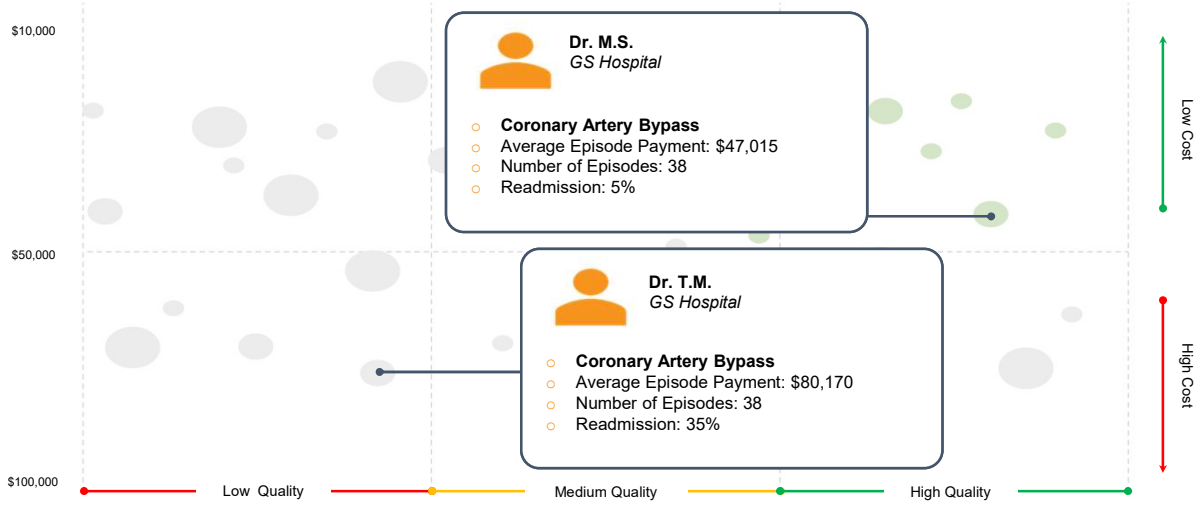
Based on Healthgrades.com user reviews as of 01/13/2021

STIMATED WAIT TIME FOR APPOINTMENT

1 to 2 Weeks

Often appointments become available sooner. Please contact the physician's office to inquire about scheduling an appointment.

Provider Selection



* High-value specialist identification process conducted utilizing

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MPL and Value-Based Care: Takeaways

- VBC has multiple dimensions, and is redefining almost every single aspect of healthcare delivery (and reimbursement)
- The fade-away of fee-for-service and the movement to value-based care *is aligned with the notion of proactive risk management*
- We need to get our data in order. The unique insights from malpractice claims should be an integral component of "central intel" for healthcare entities
- Issues related to social and economic inequities will play an increasingly greater role, not just in value-based care but will emerge more and more in malpractice allegations
- The emphasis on value will inevitably increase patient expectations. As they go higher, unexpected outcomes could spur more claims of liability.

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Questions?