



New York State Senate Insurance Committee

New York State Senate Health Committee

New York State Senate Codes Committee

Public Hearing

Medical Malpractice

Testimony Outline of the

Healthcare Association of New York State

December 1, 2009

The Healthcare Association of New York State (HANYS) thanks the Senate Committees for holding this public hearing on medical malpractice issues. HANYS is hopeful that the Senate will provide much-needed leadership to forge meaningful and effective changes in the adjudicatory, financing, insurance and health delivery systems to bring fairness and equity to the malpractice resolution process.

The following are highlights of HANYS' remarks. Since we are testifying together with the Greater New York Hospital Association (GNYHA) and the Iroquois Healthcare Alliance (Iroquois), we do not intend to repeat the points made by our colleagues. HANYS wishes to make it eminently clear, however, that HANYS fully endorses and supports the hospital community's proposals as described in GNYHA's and Iroquois' testimony.

The Tort System

The tort system is a centuries-old legal device designed to compensate individuals injured due to negligence or intentional conduct. The original goals of the system, as valid today as they were hundreds of years ago, are threefold:

- To provide adequate and reasonable compensation to the injured person;
- To provide compensation efficiently and equitably; and
- To deter future similar injury-causing behavior.

The current medical malpractice adjudicatory system fails on all three counts. Compensation amounts vary wildly. It is no secret that compensation awards, and concomitant settlements, in the First and Second Appellate Departments may reach record-breaking heights while those for similar injuries in other parts of the state may be a fraction of downstate amounts. The reasonableness of compensation is often a function of geography, legal maneuvering and judicial tolerance or intolerance.

With regard to the efficient disposition of cases, medical malpractice cases are renown for their length. Those injured from malpractice wait years for cases to be resolved. Meanwhile, defense costs rise. The emotional and financial tolls extracted by the slow and grinding litigation system are hardly the products of efficiency.

Compensation results cross the population as a whole are not equitable. A case is commenced partly because of the attorney's evaluation of the merits and partly because of an evaluation of the potential profit to be made. A strong case on the merits will not be brought if the anticipated result does not yield sufficient profit. A marginal case may be worth the risk of litigating if the estimated payoff is sufficiently handsome.

How are cases settled? Within the parameters of what an appellate court will tolerate, plaintiff and defense counsel barter the outcome. The amount of available liability insurance, evaluation of a trial outcome and the calculation of the contingency fee focus the process. The case settles or continues to proceed.

To describe our current lottery-like compensation system as "reasonable", "efficient" or "fair" is a gross misstatement. Cases evaluated as low-worth aren't brought; similar injuries are compensated on the basis of geography; and the process takes many years to complete.

As to the third goal, deterrence, trends over the last few decades provide little support for the proposition that case-by-case litigation has much affect on the number or size of compensable malpractice events. Although it is intuitively appealing to believe that a compensated case based on “XYZ” behavior will deter future acts of XYZ, there is simply scant evidence that this is accurate. Perhaps this is so because a compensable case is based on behavior that deviates from standard practice and “standard” practice is what the health care community determines and follows.

The Hospital System of Insuring Against Malpractice Risk

The hospital system of financing risk is significantly different from that applicable to physicians and other practitioners. In New York State, unlike physician liability insurance, hospital malpractice insurance premiums are not set or regulated by the Insurance Department. Hospitals purchase insurance in the marketplace. Since the financial risk to a hospital is significantly greater than that of an individual practitioner, hospitals’ financing requirements are more complex. Often they involve multiple financing arrangements.

Primary insurance, for example, may include high deductible levels that a hospital must self-finance. As a general matter, the higher the deductible, the lower is the relative cost of the insurance. But hospitals generally require more than primary insurance. Reinsurance layers above primary limits are common. Reinsurance, however, may involve several self-insured and insured levels, self-insured per-claim limits with no annual limits or other highly variable arrangements.

Two of the most significant factors in the cost of reinsurance are the financial health of the self-insuring hospital and the primary carrier. The financial fragility of hospital system is well documented. Our colleagues in the malpractice market in New York will likely describe their precarious financial situation. As a result, we have witnessed a steep increase in reinsurance premiums charged by large, often global, reinsurers. Individual hospitals have almost no bargaining leverage in these situations and are forced to pay dictated prices simply to obtain coverage.

New York's malpractice insurance market is unattractive to national carriers. In an environment where competition is low, available carriers are suffering due to years of regulatory policies and decisions and hospitals are financially frail, the 'marketplace' is hardly open or healthy. The malpractice insurance market desperately needs stability and healthy carriers. Only then will hospitals be able to find some modest relief in their marketplace system.

Proposals

As indicated at the outset, HANYS endorses, supports and encourages your action on the hospital community's proposals including:

- Establishment of malpractice "special parts" at the trial level of the Supreme Court system;
- Enactment of a "Sorry Works" program to encourage early and candid communication between practitioners and patients free of the fear that honest expressions of remorse will become litigation points; former Senators Obama and Clinton co-sponsored "Sorry Works" legislation earlier this decade;
- Enact a medical indemnity fund to finance high-dollar cases;
- Enact a no-fault compensation mechanism for neurological impairment cases;
- Enact a cap on non-economic losses.

Further, we urge your action on several proposals our colleagues in the liability insurance business will describe. The "legacy debt" of MMIP, the creation of a more broadly-based joint underwriting association, physician primary coverage levels, adequate financing of excess coverage and other proposals are long overdue.

HANYS appreciates the opportunity to testify and would be pleased to respond to questions.



Greater New York Hospital Association

555 West 57th Street / New York, N.Y. 10019 / (212) 246 - 7100 / (212) 262 - 6350

Kenneth E. Raske, President

**TESTIMONY OF
GREATER NEW YORK HOSPITAL ASSOCIATION
BEFORE THE
NEW YORK STATE SENATE STANDING
COMMITTEE ON INSURANCE,
COMMITTEE ON HEALTH, AND
COMMITTEE ON CODES,
AT A HEARING ON
MEDICAL MALPRACTICE REFORM

DECEMBER 1, 2009**

**Testimony of
Greater New York Hospital Association
Before the
New York State Senate Standing
Committee on Insurance,
Committee on Health, and
Committee on Codes
At a Hearing on
Medical Malpractice Reform
December 1, 2009**

Good morning and thank you for the opportunity to testify today. I am Susan C. Waltman, Executive Vice President and General Counsel for the Greater New York Hospital Association, which represents the interests of approximately 250 hospitals and continuing care facilities throughout New York State, New Jersey, Connecticut, and Rhode Island. All of GNYHA's members are either not-for-profit, charitable organizations or publicly sponsored institutions. Together, they provide services that range from state-of-the-art, tertiary care to the most basic primary care, given their roles as safety net providers for many of the communities that they serve.

The issues raised by today's hearing—ensuring patient safety and reforming the medical malpractice system—are of critical importance to all of us. It is unquestionably the mission of our members to provide safe, effective, and accessible health care, and indeed we strive every day to improve the care that we deliver. At the same time, all of us, patients, providers, and members of society at large, have a significant interest and investment in the proper functioning and accessibility of the system available for resolving disputes regarding the care that is delivered. Unfortunately, the current dispute resolution system is antithetical to experts' recommendations on how to deter unsafe practices; it often compensates individuals unevenly, inaccurately, and after long delays; and it is unreasonably costly. We therefore appreciate your willingness to look at ways to improve the system for the benefit of all.

For the purposes of today's hearing, I will review: 1) how the system fails to meet its intended goals of promoting patient safety and compensating injured patients; 2) the costs of today's medical malpractice system; 3) the extensive efforts being undertaken by providers to reduce

adverse events and improve patient safety; 4) how the dispute resolution system can be improved and its costs reduced; and 5) why certain proposals being discussed will unnecessarily add to the cost of the health care system.

I. The Failure of the Current System to Meet its Intended Goals

Despite all of the resources that go into adjudicating and redressing claims of medical malpractice, the current malpractice system falls far short of meeting its intended goals of deterring unsafe practices and effectively compensating individuals injured by the negligence of health care providers.

Deterring Unsafe Practices—With respect to the goal of deterring unsafe practices, patient safety experts recommend that the best way to improve the safety of care is to provide a “culture of safety” that relies heavily upon teamwork, transparency, and the ability to report and discuss errors without blame. The current tort system is by definition a system that assigns blame and therefore runs contrary to experts’ recommended approaches for most effectively deterring unsafe practices. For discussions of these recommended approaches and the negative impact that concerns about blame or reprisals have on safety, see, “To Err is Human: Building a Safer Health System,” Institute of Medicine, 1999; and the Institute for Healthcare Improvement’s Web site on building a culture of safety, which can be accessed at www.ihl.org. See also Studdert, Mello, and Brennan, “Medical Malpractice,” *NEJM*, Jan. 15, 2004: 283, which discusses the “conflicting cultures” of patient safety and the nation’s tort system.

Compensating Injured Persons—With respect to the related goal of compensating persons injured through negligence, the current system also does not do an effective job of ensuring fair and proper payments to those injured parties. Among the most-quoted studies regarding the nature and character of medical malpractice claims is a study undertaken by medical malpractice experts affiliated with Harvard’s School of Public Health, Brigham and Women’s Hospital, and Harvard’s Risk Management Foundation. That study concluded that 3% of the claims reviewed did not involve any injuries; 37% of the claims reviewed did not involve errors; and yet 28% of the claims that involved injuries but no errors nevertheless resulted in compensation to the

plaintiff. Of those claims that did involve errors, 73% resulted in compensation while 27% did not. Not surprisingly, claims without errors were more likely to go to trial than those with errors, and the cost of defending those claims was significant. In addition, the average time between injury and resolution was five years, and one in three claims took six years or more to resolve. Conversely, as is often reported, many patients injured by negligence do not bring claims, in part due to limited access to the courts caused by the system's high costs. Moreover, the key predictor of whether a payment is made when a claim is brought is not the presence of negligence, but the degree of the claimant's disability. See Studdert, Mello, Gawande, Brennan, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *NEJM*, May 11, 2006: 2024; and Studdert, Mello, and Brennan, "Medical Malpractice," *NEJM*, Jan. 15, 2004: 283.

As currently constructed, therefore, the existing medical malpractice system does not effectively serve its intended goals. At the same time and as discussed in more detail below, the medical malpractice system extracts an enormous amount of resources from the health care system at large that can be better applied to improving patient safety and access.

II. The High Cost of the Current Dispute Resolution System

New York State's medical malpractice system diverts tremendous resources from the State's health care system. According to a recent Congressional Budget Office study, providers nationwide will incur \$35 billion or about 2% of total health care expenditures in direct costs of malpractice liability coverage in 2009. In New York State, the relative costs are much higher: GNYHA estimates that hospitals incur almost \$1.6 billion annually in direct medical malpractice costs, representing more than 3% of their total operating costs and more than 8% of their operating costs other than personnel costs. Physicians, too, face high medical malpractice costs. For example, obstetricians in certain areas of New York State pay annual medical malpractice premiums of close to \$200,000 per year. Given that the State Medicaid program pays only approximately \$1,700 for prenatal care, a vaginal delivery, and post-natal care combined, an obstetrician would have to deliver nearly 120 Medicaid-covered babies before even covering his or her cost of medical malpractice insurance.

The High Administrative Costs of the System—Studies often point to the unreasonably high “administrative” costs of the nation’s medical malpractice system as part of the reason for the system being so costly. In a study undertaken by Studdert, Mello, Gawande, Brennan, et al., the authors concluded that the system’s “overhead costs are exorbitant,” with the total cost of litigating claims equaling 54% of the compensation paid to plaintiffs, and 22% of these administrative costs being attributable to claims with no error. “Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” *NEJM*, May 11, 2006: 2024. The same study indicated that the average time between injury and resolution was five years, which represents a long time for defendants to endure uncertainty and time away from patient care. The toll is no less of course for plaintiffs, who must often await the outcome of litigation for years. A recent study by Milliman similarly found that only 39% of premium dollars end up in the hands of plaintiffs due to the tremendous overhead cost of the medical malpractice dispute resolution system. See “Retooling Medical Professional Liability,” Milliman Health Reform Briefing Paper, 2009.

Debunking Attacks on Insurance Companies—GNYHA is aware that some people argue that the reason for the high cost of medical malpractice insurance is that there is a fundamental problem with the insurance carriers, either with their books or their reserves or their accounting methods. This argument has also been raised in response to concerns expressed with regard to the deficits that some of the State’s physician malpractice carriers are experiencing.

While GNYHA does not subscribe to the theory that the problem with medical malpractice insurance lies with some form of mismanagement or over-reserving by insurance companies, there certainly can be no complaint that this phenomenon goes on with respect to hospital coverage. Most hospitals in New York State do not purchase commercial malpractice insurance, or if they do, it is often only for their initial layers of insurance and/or for reinsurance at higher levels. This is so because the cost of purchasing commercial insurance has exceeded the reach of most hospitals. Many hospitals therefore have established self-insured trusts or risk retention groups that cover one or more layers of their potential medical malpractice exposure and costs. If they have not sufficiently reserved for their claims, they must pay higher “premiums” or make retroactive adjustments to their “premiums.” If they have over-reserved, presumably they would

receive “dividends” or off-sets against future premium obligations. Still other hospitals carry no insurance coverage at all, relying instead on operating revenues or reserves they have created to cover the cost of claims. Therefore, without even getting into the midst of the debate that seems to exist about carrier accounting, the problem simply cannot and does not exist with respect to hospital coverage.

The High Cost of Coverage for Obstetrical Services—The most significant cost of medical malpractice coverage for hospitals is the cost of coverage for obstetrical (OB) care, due in great part to the large settlements and awards related to neurologically impaired newborns who often require significant care during their lifetime. In New York State, the cost of coverage for obstetrical care can represent from 35–50% of a hospital’s total coverage, depending on the year and the hospital. Given the significant costs associated with medical malpractice coverage for OB services, many hospitals are not surprisingly experiencing significant operating losses associated with these services. As discussed in the press last year, one hospital in Brooklyn had requested to close its OB service because the service represented 33% of the hospital’s losses, although the service represented only 12% of the hospital’s discharges. The hospital cited its medical malpractice costs for OB as accounting for a significant portion of those losses: 40% of the hospital’s medical malpractice costs were attributable to its OB service, again even though the service represented only 12% of total discharges. Ultimately, the New York State Department of Health denied the hospital’s request to close its OB service due to the widespread need for the services in the community in which the hospital is located.

Another hospital has reported that its malpractice expense for each delivery is \$9,400. Excluding the malpractice expense, the hospital’s net income for each delivery of a Medicaid covered newborn, for example, would be \$1,500. Taking into account its malpractice expense, however, *the hospital actually suffers a loss of \$8,000 each time it delivers a Medicaid-covered newborn.* Given that Medicaid covers 60% of this particular hospital’s total newborn discharges, the hospital, like others, is experiencing significant losses from providing OB services.

Evidence That Many OB Adverse Outcomes Are Not Due to Provider Negligence—Although the extraordinary cost of OB coverage and related losses are due in great part to cases

of neurologically impaired newborns, more and more evidence indicates that these outcomes are often not sensitive to medical intervention nor are they due to provider negligence. For example, studies have concluded that the prevalence of cerebral palsy has not decreased, notwithstanding that perinatal medicine has improved and C-Section rates have increased, suggesting that birth injuries are not caused by provider negligence. In addition, well-designed studies have shown that lack of oxygen during the birth process causes only a small proportion of cerebral palsy cases, and despite, serious efforts, cerebral palsy due to birth asphyxia has not been shown to be preventable. Nelson, "Can We Prevent Cerebral Palsy?" NEJM, October, 30, 2003: 1765; MacLennan, Nelson, Hankins, and Speer, "Who Will Deliver Our Grandchildren? Implications of Cerebral Palsy Litigation," JAMA, October 5, 2005: 1688.

Thus, while hospitals across New York State spend anywhere from \$560 million to \$800 million per year on malpractice coverage for their OB services, a great portion of these costs are attributable to outcomes that providers cannot change and that are not attributable to provider negligence, thereby proving the theory that the key predictor of whether a payment is made when someone brings a claim is not the presence of negligence but the degree of disability. While the patients involved do, by all means, require significant care, GNYHA strongly urges that the source of funding for such care be assumed by society at large, through insurance or the creation of specific neurologically impaired newborn funds, rather than being the sole responsibility of providers who cannot change the outcome of a case through the delivery process.

Severity Not Frequency of Claims as the Issue—These high costs of hospital medical malpractice coverage costs exist in spite of the fact that the number of claims asserted against hospitals has leveled off or even declined in recent years, a development that GNYHA attributes to hospitals' strong patient safety initiatives. What has driven the increase in coverage costs has been the increase in the "severity" of cases being brought, with providers in certain states, including New York State, experiencing a number of extraordinarily large jury awards, in turn driving increases in the size of the settlements reached. Critics of hospital efforts to obtain cost relief sometimes point to the fact that the rate of increase in premiums and/or the severity of claims merely reflect the rate of increase in the cost of health care. However, even if this statement were correct, the cost of coverage is not any less expensive for hospitals. Moreover,

hospitals are acutely cognizant of, and directly affected by, the spiraling costs of the component parts of delivering health care, such as pharmaceutical, technology, and labor costs, while at the same time, all payers are trying to reduce their payments to hospitals.

Hospitals' Poor Financial Condition—The high cost of medical malpractice coverage must be viewed in the broader context of hospitals' poor financial condition and threatened additional cuts in payments by the State Medicaid program as well as the Federal Medicare program. *Over the last three years, New York State has cut Medicaid payments to hospitals six times, causing a net recurring loss to hospitals of \$1 billion each year, an amount equal to 11% of projected baseline Medicaid payments.* These cuts, combined with the country's recession, have driven hospital margins to the lowest level since the early 1990s. Hospitals in New York State experienced a total margin in 2008 of -2.3%, and their total margin in 2009 is projected to drop to -3.0%. For safety net hospitals, the situation is expected to be even more dire: it is projected that their margin will drop to -7.6% in 2009. These projected losses do not even take into account the additional Medicaid cuts that have been proposed by the Governor in order to close an estimated \$3.2 billion budget gap for the 2009–2010 State fiscal year. Although GNYHA remains hopeful that hospitals will not be forced to suffer a seventh round of Medicaid cuts in a three year period, we believe that any further cuts will force some hospitals to curtail critically needed services, if not result in the collapse of entire hospitals.

One indicator of the difficult financial times facing hospitals is the fact that 40 hospitals have closed across New York State since 1990, which represents 14% of the hospitals that were open in 1990. Some of the closures occurred pursuant to the direction of the State's Berger Commission, while many closures occurred simply due to financial collapse. GNYHA fully expects more hospitals to close and others still to file for bankruptcy, given the difficult times facing hospitals across New York State.

Threats to the Availability of Obstetrical Care—Not surprisingly, in this environment of spiraling costs for hospitals and continuing cuts in payments, hospitals are, by necessity, looking for ways to reduce their operating costs. Given that obstetrical services are one of the biggest sources of hospital losses, hospitals are forced to move their OB service to the top of their lists of

services to curtail or cut in order to preserve the hospital as a whole for the benefit of their broader communities. And, as economic conditions continue to take their toll on the State budget, and in turn on hospitals dependent on Medicaid and serving large numbers of uninsured individuals, hospital efforts to eliminate services that are not sustainable financially will only accelerate.

New York State’s Investment and Interest in OB Care—The State of New York has a large interest and “investment” in this problem. The State’s Medicaid program covers nearly 50% of the deliveries Statewide. In New York City, the Medicaid program covers nearly 60% of the deliveries, and in the boroughs of Brooklyn and the Bronx, it covers nearly 70% of the deliveries. Reductions in the availability of OB services in certain communities, whether due to reductions in the size of an OB service or the total collapse of a hospital, will unquestionably undermine a vitally important network of care needed by the population at large and Medicaid recipients in particular.

The Extraordinary Costs of Defensive Medicine—In addition to the high cost of coverage for medical malpractice liability, there is also the additional extraordinary cost of unnecessary tests and care provided due to fears of malpractice claims, often referred to as “defensive medicine” or sometimes “assurance behavior.” While the figures ascribed to defensive medicine vary, the figures are always staggering. A December 2008 report by McKinsey & Company estimates that defensive medicine costs the U.S. health care system anywhere from \$150 billion to \$190 billion per year. Similarly, a 2008 report by PricewaterhouseCoopers estimates that the combined cost of medical liability and defensive medicine in the U.S. is \$210 billion per year. Even conservative estimates put the annual cost of defensive medicine at \$25 billion, which translates to \$350 billion over a decade, with inflation. See, “Accounting for the Cost of US Health Care: A New look at Why Americans Spend More,” McKinsey & Company, Dec. 2008; “The Price of Excess: Identifying Waste in Healthcare Spending,” PricewaterhouseCoopers’ Health Research Institute, 2008; and “The Factors Fueling Rising Healthcare Costs,” Prepared by PricewaterhouseCoopers’ Health Research Institute for American’s Health Insurance Plans, 2006.

While there is clearly debate as to how much of today's health care costs are attributable to defensive medicine, there is no question that defensive medicine carries a very high price tag and is widespread in our system, often affecting diagnostic testing, such as imaging tests, more so than therapeutic procedures. In a study of physicians practicing in high-liability specialties undertaken by Studdert, Mello, Sage, et al., nearly all physicians (93%) reported practicing defensive medicine. "Assurance behavior" such as ordering tests, performing diagnostic procedures, and referring patients for consultations, was very common (92%). Defensive medicine also correlated strongly with a physician's lack of confidence in his or her liability insurance and perceived burden of insurance premiums. See Studdert, Mello, Sage, et al., "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment," JAMA, June 1, 2005: 293, 2609.

Similarly, in a study undertaken by Harris Interactive and released in 2002, 79% of physicians surveyed said that they ordered more tests, 74% said they referred patients to specialists more often, and 41% said they prescribed more medications, than they would based only on their professional judgment as to medically necessary care due to fears of liability. "Fear of Litigation Study," conducted by Harris Interactive, Final Report, April 11, 2002. See also, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System," U.S. Department of Health and Human Services, July 25, 2002.

III. The Importance of Patient Safety and Reducing Adverse Events to the Extent Possible

Without question, the most effective way to reduce the foregoing costs and the acrimony associated with medical malpractice claims is to eliminate all adverse outcomes. That is of course the idealized goal of all health care providers, whose mission is to provide high quality, safe patient care at all times. Unfortunately, many adverse outcomes cannot be avoided notwithstanding the provision of careful, high quality care. As for outcomes that might occur due to provider negligence or at the very least that can be avoided in some way, GNYHA and its members take very seriously the importance of putting in place systems and mechanisms to avoid such events. Indeed, GNYHA has devoted exceptional efforts to support its members' efforts in this regard. The following provides brief summaries of some of the major initiatives

that GNYHA has undertaken with and on behalf of its members. GNYHA emphasizes that the fact that a particular member does not participate in one of GNYHA's initiatives does not mean that the member is not undertaking the same activities within its own network, with its insurer, or on its own. Indeed, GNYHA has found that its best source of "best practices" in the realm of safety is most often a member that has already undertaken a particular initiative.

Perinatal Safety Collaborative: GNYHA, in partnership with the United Hospital Fund (UHF), has undertaken an extensive Perinatal Safety Collaborative in which 45 hospitals are participating and that is designed to improve outcomes and reduce the severity and frequency of adverse events in the perinatal setting. The focus of the initiative is on the identification and implementation of standardized, evidence-based clinical and safety protocols, known as the "Perinatal Safety Bundle," across hospitals. The initiative includes team training, ongoing site visits, educational calls, and regular meetings of the participating hospitals.

Clinical Quality Fellowship Program: GNYHA and UHF have created a fellowship program designed to build a sustainable infrastructure that will support quality improvement in hospitals across the region through the development of a cadre of physician leaders who will implement and promote quality improvement activities in their institutions. The fellowship is an intensive 15-month structured program and consists of educational conferences, conference calls, and Capstone initiatives. Participating hospitals put forward promising physicians for the program as well as more seasoned physicians who act as their mentors throughout the program.

Infection Prevention Initiatives: GNYHA has undertaken a large number of very substantive initiatives designed to prevent and eliminate infections throughout its member hospitals. The following lists the separate infection prevention initiatives undertaken, the entities with which GNYHA has been partnering for each of them, and the number of hospitals participating:

- **Central Line-Associated Bloodstream (CLAB) Infections Collaborative**—GNYHA, UHF, and the New York State Department of Health (DOH) have worked with 46 hospitals to develop and implement evidence-based procedural standards to be followed when inserting a central line. Hospitals participating were able to reduce their infection rates by an average of 54% collaborative-wide. GNYHA's Infection Control Steering

Committee will be identifying ways to try to sustain these results and to spread the collaborative methodology to other departments and areas of the hospital.

- ***Clostridium difficile* (C. difficile) Collaborative**—GNYHA, UHF, and DOH are currently working with 42 hospitals to prevent and eliminate *C. difficile* infections by identifying and implementing a set of evidence-based interventions.
- **Methicillin-resistant *Staphylococcus aureus* (MRSA) Project**—GNYHA, together with IPRO, New York State’s quality improvement organization, is working with 72 hospitals to prevent and reduce the transmission of MRSA infections through early identification and implementation of universal precautions.
- **Antimicrobial Stewardship Project**—GNYHA, UHF, and DOH are working with three hospitals and three long term care facilities on a pilot project to implement and test an antimicrobial stewardship program. The goal is to develop a set of evidence-based guidelines that can be used by an interdisciplinary team as they implement an effective and sustainable program to manage and ensure the appropriate choice and use of antibiotics and in turn to minimize resistance to, and the costs of antibiotics.

Critical Care Leadership—GNYHA and UHF have brought together leaders in critical care in the region, who work together to improve outcomes in intensive care units by sharing best practices, sharing clinical training resources to maximize efficiencies and standardize care, and implement the collaborative methodology to focused initiatives.

Rapid Response Systems—GNYHA and UHF are working with 38 hospitals to develop systems that include designated teams of clinicians that respond to early signs of acute deterioration and bring critical care expertise to the bedside before patients decline into a critical state.

Pressure Ulcer Collaborative—GNYHA is working with the Continuing Care Leadership Coalition (CCLC) to implement the use of standardized, evidence-based clinical best practices across the continuum of care and to create a sustainable approach to the prevention, assessment, management, and documentation of pressure ulcers.

Reducing Preventable Readmissions—GNYHA is working with UHF and CCLC to improve the care transition process across all settings of care. Ultimately, GNYHA will identify factors that contribute to preventable hospital readmissions and then, using the collaborative methodology, develop and implement best practices to reduce such readmissions.

Health Information Technology Implementation and Support—GNYHA recognizes the value that health information technology (HIT) can bring to patient safety and quality initiatives in hospitals and thus is devoting considerable efforts to assisting hospitals in their acquisition and implementation of HIT, focusing heavily on ensuring that hospitals are able to receive Federal funding under the American Recovery and Reinvestment Act of 2009 for the “meaningful use” of HIT.

Workforce Development—GNYHA has worked closely with 1199 SEIU and DOH to educate frontline staff on the role they can play in improving patient care and satisfaction and to assist hospitals in training staff on improving infection prevention practices related to hand-hygiene, immunizations, and environmental cleanliness. GNYHA has also worked with the Jonas Center on Nursing Excellence to strengthen the partnership between bachelor degree nursing programs and hospitals in order to develop staff nurses into adjunct clinical faculty to address faculty shortages, to improve staff satisfaction and retention, and to improve the preparation of new nurses.

Root Cause Analysis Training—Over the years, GNYHA has devoted considerable efforts to teaching members the skills needed to identify the root causes of errors and in turn strategies for avoiding them. In this regard, GNYHA has provided extensive training to its members as well as developed a guide to undertaking a root cause analysis.

Communication Skills Training—GNYHA also believes in the importance of full disclosure, meaningful apologies, and early offers of compensation, when appropriate. GNYHA has therefore provided extensive training on how to develop and improve effective communication skills to accomplish these goals.

Hospitals' Commitment to Patient Safety—GNYHA's commitment to patient safety and quality as demonstrated above is a reflection of its members' strong commitment to delivering safe care to each and every patient. Indeed, GNYHA and its members take very seriously the importance of learning from and responding to adverse outcomes in order to ensure that they do not recur. For additional information about the foregoing initiatives, please see the attached chart, entitled, "GNYHA Quality and Patient Safety Initiatives: Improving Care and Safety, Reducing Health Care Costs, and Enhancing Efficiency."

IV. Improving and Reducing the Costs of the Current Medical Malpractice System

It is important that New York State reform its malpractice system to ensure that persons injured through negligence are compensated fairly and swiftly, safe practices are encouraged, and unnecessary costs and defensive medicine are eliminated to the extent possible. It is critical therefore that the "politics" of reform are put aside, and meaningful solutions to the problem are seriously examined. This must be done to ensure the availability, affordability, and quality of care across New York State. GNYHA puts forward the following solutions to help better align the system's goals of safety and fair compensation with promoting affordable, safe health care.

Development of a No-Fault Neurologically Impaired Newborn Fund—Given that science and medicine indicate that many cases of neurologically impaired newborns are not sensitive to medical intervention and thus not the result of provider negligence, New York State should seriously consider creating a no-fault compensation system for such individuals. Such a system would make payments to individuals based solely on injury, thereby eliminating the necessity of adjudicating causation and, in turn, minimizing the cost of litigation and permitting more health care resources to be devoted to improving patient safety. Such a system would also recognize that responsibility for the cost of care for such individuals is more properly the obligation of society at large and not only that of providers who often feel forced to settle claims or face extraordinarily large awards, not because of negligence, but because of the unfortunate degree of disability involved.

Critics of creating a no-fault fund in New York seem to want no change in the status quo and will say that no-fault funds established in other states (e.g., Virginia and Florida) do not work well or are not well funded. In fact, those funds are adequately funded for their current caseload, and the vast majority of participants are satisfied with those systems in contrast to an acrimonious, lengthy dispute resolution process. GNYHA notes that New York State has considered establishing no-fault neurologically impaired newborn funds in the past, due in great part to the science supporting them and the value of eliminating lengthy litigation over outcomes that often cannot be avoided. Estimates of the costs of such funds understandably vary depending on the scope of cases covered.

From a provider standpoint, creating such a fund could reduce hospital coverage costs by approximately 40% or \$640 million each year, with a portion of those savings accruing from eliminating the cost of litigation of such cases and a portion coming from there being a more broad-based, societal approach to covering the costs of care. Funding for such purposes could come from a variety of sources including third party recoveries obtained by the State Medicaid program, in particular from the proceeds of special needs trusts; assessments on the broader world of insurance carriers, many of which stopped writing medical malpractice coverage due to its high losses; and other public and private sources. GNYHA and its members believe that providers should undertake meaningful initiatives to eliminate all adverse events that can be avoided and therefore take the position that participation in such safety initiatives must go hand in hand with the creation of such a fund.

Development of a Medical Indemnity Fund for Neurologically Impaired Newborns—

Separate from the proposal to create a no-fault system for covering the cost of care for neurologically impaired newborns, there is also merit to creating a medical indemnity fund to cover the cost of caring for such individuals. Under this model, cases would still proceed through the judicial system for the purposes of determining causation and fault, but the cost of future medical care required by settlements or awards would be paid from a medical indemnity fund as those costs are incurred over time, thereby avoiding the overcompensation that can occur under the current system, which requires forecasting future care needs. Funding sources could be the same as those referenced under the foregoing no-fault fund. The creation of such a medical

indemnity fund would help reduce the cost of the current system as well as spread the cost of caring for these individuals more broadly and equitably, again in recognition of the fact that many adverse outcomes in this area are not due to the negligence of providers. If adopted, this model could reduce hospital coverage costs by 20-25% or \$320 million to \$400 million each year.

Improved Dispute Resolution Mechanisms: Health Courts and Mediation—The existing system for resolving claims is lengthy, unnecessarily costly, inexact, and ineffective. Serious consideration should be given to creating health courts. In their purest form, these courts would be administrative in nature, but they could just as easily be established as special parts within the current judicial system, in much the same way as bankruptcy and patent courts exist at the Federal level and family and surrogate courts exist at the State level. One way or the other, the courts would use adjudicators who are specially trained with regard to the substance of medical malpractice cases as well as with regard to mediation skills. The courts would also have neutral experts available; would apply evidence-based standards; and use guidelines for compensating non-economic losses. Such a system would improve efficiencies, enhance consistency, and yet potentially expand compensation at the same time. GNYHA draws attention to the benefits of a model developed by the New York City Health and Hospitals Corporation that relies upon an active case conferencing process handled by a judge with expertise in medical malpractice cases as well as dispute resolution methods, a topic that we understand will be discussed in more detail later. Regardless of this mechanism, GNYHA notes that studies indicate that the existence of a more efficient, less lengthy, and less rancorous system for adjudicating medical malpractice claims can have a positive effect on reducing defensive medicine practices.

Development of Clinical Guidelines—As the entire nation looks at ways to identify effective practices and eliminate wasteful ones, it should also consider developing clinical practice guidelines to help establish appropriate standards of care in general and in malpractice cases in particular. While there may be downsides to the development of practice guidelines, agreement as to what care is effective will improve care as well as minimize areas of dispute in malpractice cases. In this manner, the cost of the system can be reduced, providers can be better able to defend themselves when there is no negligence, and patients may be able to be compensated

more quickly when negligence can be more readily established. GNYHA recognizes that a broad array of guidelines, toolkits, and best practices already exist. What GNYHA recommends is the establishment of broadly accepted consensus standards, some of which might already exist and others that might need to be developed or refined. This could be done either at the national level under the auspices of the Institute of Medicine and the Agency for Healthcare Research and Quality or at the State level under the auspices of the New York State Department of Health.

Programs Focusing on Disclosure, Apology, and Early Offers of Compensation—In order to improve transparency, enhance patient satisfaction, and reduce costs associated with medical malpractice claims, many hospitals have developed policies and programs that encourage full disclosure, meaningful apologies, and early offers of compensation, when warranted, following an adverse event. Although the primary goals of such programs are to enhance safety and fulfill ethical and legal obligations to patients, some hospitals that have instituted “proactive” disclosure programs have experienced the unexpected benefit of decreasing the cost of their malpractice claims. Key to the success of such programs seems to be the open, honest exchange of information that facilitates the early settlement of meritorious claims and vigorous defense of non-meritorious ones.

GNYHA is a strong advocate of such programs and, as indicated earlier in this testimony, has offered communication skill training to its members for a number of years. The training is designed to help staff develop and improve the communication skills needed to accomplish effective disclosure. GNYHA also strongly urges that New York State adopt legislation that would provide protection of such discussions in order to promote the truly full disclosures and truly meaningful discussions that are required to accomplish the purpose of such programs.

Caps on Non-Economic Damages—Although controversial in a state such as New York, one of the most effective ways to reduce medical malpractice coverage costs is to impose reasonable caps on non-economic damages, meaning damages in the nature of pain and suffering. Many states have enacted caps on non-economic damages in order to address high medical malpractice costs, thereby also eliminating some of the unpredictability, variability, and inequities associated with large awards for pain and suffering. As for the potential reduction in direct medical

malpractice costs associated with imposing caps, according to a study undertaken by Milliman in 2004, a cap of \$250,000 on non-economic damages would reduce medical malpractice premiums for hospitals and physicians in New York State by 24%. This would mean that hospitals in New York alone could reduce their cost of delivering care by several hundred million dollars and ideally redirect those savings to improving the quality and accessibility of the care that they provide.

This figure does not capture by any means the much larger savings that would occur due to the related reduction in defensive medicine practices. Studies by Kessler and McClellan have concluded that the adoption of “direct reforms,” such as caps, significantly reduces defensive medicine. Indeed, Kessler and McClellan have estimated that the adoption of such reforms could reduce hospital expenditures by 5–9% per year within three to five years of adoption, a reduction that they projected in 1996 could yield \$50 billion per year in health care savings across all providers. Their studies over the years also looked at the impact of such reform-induced reductions in treatment intensity on health outcomes and concluded that such reductions would have negligible effects on health outcomes. Thus, not only do direct reforms such as caps reduce the direct cost of coverage, they also reduce the costs of unnecessary tests and care without negatively affecting the quality of care provided. See Kessler and McClellan, “Do Doctors Practice Defensive Medicine?” National Bureau of Economic Research, February 1996: Working Paper 5466; and Kessler and McClellan, “How Liability Law Affects Medical Productivity,” *Journal of Health Economics*, Nov. 2002: 931.

V. Proposals that Will Greatly Increase the Cost of Coverage

Although there is much discussion both nationally and in New York State about ways in which to improve and reduce the costs of the medical malpractice dispute resolution system, there are a number of proposals that have been discussed in New York that will most definitely *increase* the costs of the current system. GNYHA is adamantly opposed to these proposals and will discuss them in order of their negative cost impact on premiums.

Modifying the Plaintiff Attorney Fee Schedule—First, there have been several proposals to modify the State’s plaintiff attorney contingent fee schedule for medical malpractice cases. One proposal is to eliminate the current graduated fee schedule (the schedule reduces the permissible percentage fee as the size of the recovery increases) so that plaintiff attorney fees could be one-third across the board. For example, an attorney winning a \$6 million award for a plaintiff would be entitled to a \$750,000 fee under current law. As proposed, the attorney would be entitled to a 167% increase in that fee, or \$2 million. *Actuaries estimate that this proposal, if enacted, would increase hospital coverage costs by as much as 25–40% or \$400 million to \$640 million per year.* The following chart demonstrates the tremendous increases in attorneys fees that would occur if the existing fee schedule were eliminated and fees could be one-third across the board.

Plaintiff Attorney Contingent Fees			
Settlement/ Award	Proposed:		
	Current: Sliding Fee Schedule	1/3 Settlement/Award Across the Board	% Fee Increase
\$250,000	\$75,000	\$83,333	11%
\$500,000	\$137,500	\$166,667	21%
\$750,000	\$187,500	\$250,000	33%
\$1,000,000	\$237,500	\$333,333	40%
\$1,500,000	\$300,000	\$500,000	67%
\$2,000,000	\$350,000	\$666,667	90%
\$3,000,000	\$450,000	\$1,000,000	122%
\$6,000,000	\$750,000	\$2,000,000	167%

Yet another proposal would adjust the current contingent fee schedule by increasing the underlying fee bands or tiers. *Actuaries estimate that this proposal would increase hospital coverage costs by 15% or \$240 million per year.*

Over the years, many states have enacted limitations on the size of contingent fees in medical malpractice cases for the express purpose of trying to control the cost of medical malpractice coverage. Such limits serve both to protect plaintiffs by ensuring that a greater share of any recovery goes to the injured party as well as to help minimize the cost of medical malpractice coverage. The use of a sliding fee schedule in particular is typically adopted in order to remove an attorney’s incentive to pursue excessive awards while at the same time preserving access to the judicial system that a contingent fee schedule provides.

New York State's contingent fee schedule for medical malpractice actions was enacted in 1986 as part of a broad package of reform measures for precisely the same reasons, namely, to help control the spiraling costs of medical malpractice coverage that providers were experiencing at the time and to ensure that injured parties receive a greater share of their recovery. Other states, such as Connecticut, have similar sliding fee schedules.

While there is debate about exactly how much premiums and other coverage costs would increase if the fee schedule were changed, it is fair to say that any change in the contingent fee limitations will unquestionably result in harm to both plaintiffs and providers because attorney fees must come out of either the pockets of the attorney's clients in the form of reduced shares of their recoveries and/or out of the pockets of hospitals and physicians in the form of increased coverage costs. GNYHA understands that trial attorneys believe that they are due an increase because the fee schedule has not been adjusted in recent years. However, the reason for the current unsustainably high levels of coverage costs is that the severity of recoveries has increased significantly in recent years. Given that attorney fees are based on the underlying recovery amount, plaintiff attorneys have quite clearly received increases in their fees as the underlying recoveries have increased over time. In addition, attorneys have the opportunity to request the court to grant them a larger share of their clients' recovery, an opportunity that attorneys definitely pursue. One way or the other, it is inappropriate to consider either reducing payments to plaintiffs and/or increasing costs to providers through a statutory modification of the schedule.

Extending the State's Statute of Limitations—The second proposal discussed in the last year that would significantly add to the cost of coverage is a proposal to modify the State's statute of limitations for medical malpractice cases so that the statute would run not from the act, omission, or failure complained of, which is the current formulation, but from “when one knows or reasonably should have known of the alleged negligent act or omission and knows or reasonably should have known that said negligent act has caused an injury.” *Actuaries estimate that extending New York State's statute of limitations in this manner would increase hospital coverage costs by 15-25% or \$240 million to \$400 million per year.*

While it is always unfortunate when someone's otherwise worthy claim is barred by a statute of limitations, the purpose of a statute of limitations is to balance the need to provide a reasonable time period within which plaintiffs can bring an action against the importance of bringing appropriate finality to the period during which providers must anticipate and defend actions in the future. New York State's statute of limitations was enacted in 1975 as part of a package of legislative reforms designed specifically to address the "medical malpractice insurance crisis" that existed at that time. It is therefore deliberately designed to provide reasonable access to the courts while at the same time to help control the costs of coverage by providing reasonable finality.

There seems to be the misimpression that New York State's statute of limitations is somehow unreasonably short or that it unreasonably limits access to the courts compared to the statutes of other states. In fact, New York State's basic statute of limitations (two and one-half years) is one of the longest absolute time frames in the nation. Moreover, existing CPLR provisions contain a number of mechanisms for plaintiffs to assert claims regarding injuries discovered at later points in time, i.e., pursuant to New York State's continuous treatment doctrine, tolling with respect to minors, tolling for later discovery of foreign bodies, and fraudulent concealment theory. To the extent that other states may have broader discovery rules than New York State, the majority of those states have caps on damages, thereby minimizing the cost impact of having such statutes in place. GNYHA strongly urges that New York State's already generous statute of limitations be maintained in its current form, particularly given that the proposals that have been put forward would increase medical malpractice premiums by 15-25%.

Prohibiting Defendants from Interviewing Later Treating Physicians—A third proposal would prohibit a defendant from interviewing a plaintiff's treating physician or physicians, effectively overturning the New York State Court of Appeals recent decision upholding this right. In the case of *Arons v. Jutkowitz*, the Court of Appeals upheld the longstanding principle that informal discovery of information can serve both litigants and the entire judicial system by uncovering relevant facts, thus promoting the expeditious resolution of disputes, both in medical malpractice cases as well as other cases. This decision affirmed earlier rulings that held that formal depositions or even somewhat less formal interviews attended by an adversary's counsel

are often no substitute for such off-the-record private efforts to learn and assemble information. The Court of Appeals also recognized that, while a party cannot compel a treating physician to engage in such conversations, so long as the request is authorized in a way that is compliant with the Federal Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), a request for an informal interview may be made and granted.

Perhaps even more important, actuaries project that taking away this right from defendants might increase hospital coverage costs by as much as 5% or \$80 million per year. In addition, the proposal would create an uneven playing field between plaintiffs and defendants, by permitting plaintiffs and their attorneys unlimited access to certain witnesses but denying that right to defendants. No reasonable or compelling argument has been put forward to support this proposal.

Amending the General Obligations Law—The fourth proposal would amend the State’s General Obligations Law to essentially strip from a non-settling co-defendant in a tort case the opportunity to appropriately and fairly limit its liability to its own share of a recovery by forcing the non-settling defendant to select, before trial, whether the offset to an eventual recovery should be the settling defendant’s amount paid or the non-settling defendant’s equitable share of damages. *Actuaries estimate that this proposal could increase hospital coverage costs by as much as 5% or \$80 million per year.*

Under current law, a non-settling co-defendant must decide how to properly and equitably reduce its liability only after a verdict has been rendered. Depending on the co-defendant’s choice, the court, if necessary, adjusts the jury’s award by either the amount paid by the settling defendant or the settling defendant’s equitable share of the damages as determined by the jury. In this way, the jury’s verdict is upheld.

The proposed legislation would essentially moot the judicial process and potentially enable plaintiffs to recover a verdict larger than a jury may award. The non-settling defendant would be unfairly required to choose between its options prior to the determination of its equitable share of damages. If the non-settling defendant chooses to reduce its liability by what turns out to be the

smaller amount, the plaintiff may be unjustly enriched at the non-settling defendant's expense. GNYHA recognizes that a plaintiff could conceivably recover less than the full amount a jury awards, but only because the plaintiff decided to settle with a co-defendant prior to trial. It is the plaintiff's right and choice to settle with one or more defendants, and the plaintiff presumably fully understands that a pre-trial settlement may result in less than a full recovery.

CONCLUSION

GNYHA is hopeful that today's hearings will be a catalyst for doing what needs to be done to improve both the health care system and the medical malpractice dispute resolution system. While the goals of the current medical malpractice system are laudable, the system unfortunately does not effectively or efficiently meet those goals: the system operates contrary to patient safety experts' recommendations on how to encourage safety, and it compensates individuals unevenly and often after long delays. It also extracts enormous costs from the health care system that can be better used to make health care more accessible and affordable and to enhance patient safety initiatives. Unquestionably, the system needs to be refashioned to better meet its goals; it needs to be more effective and efficient; and it needs to be far less costly.

It is critically important that we address these issues, particularly at this juncture when the nation and the State of New York are looking for ways to improve the health care system, reduce its costs, and make it more accessible and safer for everyone. GNYHA and its members are committed to improving patient safety and reducing adverse events to the extent possible. We are also committed to working with the Legislature and all interested stakeholders to improve the State's medical malpractice system. For this purpose, GNYHA strongly urges the development of special compensation funds to cover the cost of care of neurologically impaired newborns; the creation of health courts to improve the efficiency of the dispute resolution system; the development of meaningful clinical practice guidelines for the protection of patients and providers; and the development of programs that support disclosure, apologies, and early offers of compensation, where warranted. We are hopeful that all who have a stake and interest in the health care system are willing to do what is needed to improve the medical malpractice system for the benefit of all of us.

GNYHA Quality and Patient Safety Initiatives

Improving Care and Safety, Reducing Health Care Costs, and Enhancing Efficiency

GNYHA Initiative/Partners	Description/Goals	Next Steps	Cost Savings/Benefits
<p>Perinatal Safety Collaborative (45 Hospitals) • United Hospital Fund</p> <p>GNYHA Contact: Lorraine Ryan/Gina Shin UHF Contact: Andrea Hoberman</p>	<p>Improve outcomes and reduce the severity and frequency of adverse events in the perinatal setting.</p> <p>Implementation of standardized, evidence-based clinical and safety protocols/bundles (the <i>Perinatal Safety Bundle</i>) across hospitals.</p> <p>Measure the impact of the interventions defined in the <i>Perinatal Safety Bundle</i>.</p>	<p>Continue team training, on-going site visits, educational calls, and meetings.</p> <p>Begin data collection to assess compliance with bundle elements and impact on perinatal outcomes.</p> <p>Continue to encourage the DOH to promote this model for Statewide implementation.</p>	<p>Several collaborative hospitals report reductions in the frequency and severity of adverse events after implementation of best practices/<i>Perinatal Safety Bundle</i>.</p> <p>The following organizations have documented improvement using this approach:</p> <ul style="list-style-type: none"> • Yale New Haven Hospital—60% reduction in adverse events. • Beth Israel Deaconess Medical Center—62% reduction in high severity claims. • Ascension Health System—reduction in birth trauma from 7.358 to 3.3 adverse events per 1,000 live births. • MedStar Hospitals—reduction in OB losses by \$2 million annually.
<p>Clinical Quality Fellowship Program (16 fellows participating) • United Hospital Fund</p> <p>GNYHA Contact: Lorraine Ryan UHF Contact: Andrea Hoberman/Hillary Jalon</p>	<p>Create a sustainable infrastructure and culture supporting quality improvement in the Greater New York region through the development of a cadre of physician leaders who will implement and promote quality improvement activities throughout the region’s health care system. The fellowship is an intensive 15-month structured program.</p> <p>Cultivate new clinical talent and create a core group of quality leaders who can act as change agents within their own health care organizations.</p>	<p>On-going conference calls and educational meetings.</p> <p>Continue discussions about individual Capstone Initiatives, a pre-requisite for completion of the program.</p> <p>Curriculum revisions and application process for the Class of 2010 is underway.</p> <p>Develop a formal program evaluation.</p>	<p>Creating this “human resource” of quality improvement professionals for our member institutions is not easily quantified. However, the feedback thus far has been very positive with regard to the contributions these quality improvement professionals are already making in their respective institutions.</p>

GNYHA Quality and Patient Safety Initiatives

Improving Care and Safety, Reducing Health Care Costs, and Enhancing Efficiency

GNYHA Initiative/Partners	Description/Goals	Next Steps	Cost Savings/Benefits
<p>Central Line-Associated Bloodstream (CLAB) Infections Collaborative (46 Hospitals)</p> <ul style="list-style-type: none"> • United Hospital Fund, NYS DOH <p>GNYHA Contact: Maria Woods/Gina Shin UHF Contact: Hillary Jalon</p>	<p>Prevent CLAB infections by requiring clinicians to adhere to evidence-based procedural standards when inserting a central line.</p>	<p>GNYHA Infection Control Steering Committee will identify and implement mechanisms to sustain reduced infection rates and spread collaborative methodology to other departments.</p> <p>GNYHA will host training sessions related to CLABIs and will determine appropriate avenues for addressing pediatric and NICU CLABIs.</p>	<p>CLAB infections are the third most common healthcare associated infections reported by med/surg ICUs:</p> <ul style="list-style-type: none"> • Total annual costs nationally: \$2.7B* • Marginal costs to healthcare system: \$25,000 per episode* • Increased hospital LOS: 14–24 days** • Increased ICU LOS: up to 6 days** <p>If not present on admission, infections may impact Medicare reimbursement.</p> <p>GNYHA members reduced infection rates on average 54% collaborative-wide.</p> <p><small>*Source: Division of Healthcare Quality Promotion, National Center for Preparedness, Detection, and Control of Infectious Diseases, Coordinating Center for Infectious Diseases, Centers for Disease Control and Prevention March 2009. ** Source: American Journal of Infection Control, December 2008.</small></p>
<p>Clostridium difficile (C. difficile) Collaborative (42 Hospitals)</p> <ul style="list-style-type: none"> • United Hospital Fund, NYS DOH <p>GNYHA Contact: Maria Woods/Gina Shin UHF Contact: Hillary Jalon</p>	<p>Prevent and eliminate <i>C. difficile</i> infections by identifying and implementing a set of evidence-based interventions.</p>	<p>Continue to engage participating hospitals in data collection and analysis, sharing of best practices.</p> <p>Identify publication opportunities for the <i>C. difficile</i> collaborative related to the data collection.</p> <p>Assist members in meeting New York State's <i>C. difficile</i> mandatory reporting requirements (as of July 1, 2009).</p> <p>Develop an environmental cleaning and training video.</p> <p>Develop an antimicrobial stewardship collaborative in 2010 as a “next step” to the <i>C. difficile</i> collaborative.</p>	<p><i>C. Difficile</i> Infections:</p> <ul style="list-style-type: none"> • Total annual costs nationally: \$1.6B* • Cost per infection: \$5,682–\$8,090* • Increased LOS: 2.6–4.5 days** <p><small>*Source: Division of Healthcare Quality Promotion, National Center for Preparedness, Detection, and Control of Infectious Diseases, Coordinating Center for Infectious Diseases, Centers for Disease Control and Prevention March 2009. **Source: Short and Long Term Attributable Costs of Clostridium difficile-Associated Disease in Nonsurgical Inpatients 2008.</small></p>

GNYHA Quality and Patient Safety Initiatives

Improving Care and Safety, Reducing Health Care Costs, and Enhancing Efficiency

GNYHA Initiative/Partners	Description/Goals	Next Steps	Cost Savings/Benefits
<p>Antimicrobial Stewardship Project (3 Hospitals and 3 Long term care Facilities) • NYSDOH, United Hospital Fund</p> <p>GNYHA Contact: Maria Woods/Gina Shin UHF Contact: Hillary Jalon</p>	<p>Assist a small group of healthcare facilities, both acute care and long-term care, as they implement and test an antimicrobial stewardship program within their institutions. The goal is to develop a set of evidence-based guidelines that can be used by an interdisciplinary team as they implement an effective and sustainable program to manage and ensure the appropriate choice and use of antibiotics, and to minimize resistance to, and the costs of antibiotics.</p>	<p>Kick-off session – completed October 13, 2009.</p> <p>Continue to develop an antimicrobial stewardship tool kit which will be piloted by the participants.</p> <p>Conduct site visits at the 6 participating facilities to assess current practices and develop strategy for program implementation.</p>	<p>Effective programs can be financially self-supporting and improve patient care:</p> <ul style="list-style-type: none"> • Comprehensive programs have consistently demonstrated a decrease in antimicrobial use (22%–36%). • Annual savings of \$200,000–\$900,000 in both large academic hospitals and small community hospitals. <p><i>Source:</i> Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America guidelines for developing an institutional program to enhance antimicrobial stewardship 2006.</p>
<p>IPRO Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) Project (72 Hospitals) • IPRO</p> <p>GNYHA Contact: Maria Woods/Gina Shin</p>	<p>Under the CMS 9th Scope of Work (SOW) IPRO is seeking to prevent and reduce transmission of MRSA infections through early identification and implementation of universal precautions.</p> <p>GNYHA will assist IPRO in meeting its responsibilities as delineated under 9th SOW. This will include developing an Advisory Panel, coordinating participant communication, and implementing an “expert on call” approach to MRSA prevention and reduction.</p>	<p>MRSA prevention/improvement bundle has been developed and shared with IPRO for widespread implementation.</p> <p>Training/educational sessions for participating facilities are being planned and scheduled.</p>	<ul style="list-style-type: none"> • Total annual costs nationally of MRSA infections: \$4.2 B. <p><i>Source:</i> Infection Control Today, March 2009.</p>
<p>Critical Care Leadership Network (All members) • United Hospital Fund</p> <p>GNYHA Contact: Zeynep Sumer/Alissa D’Amelio</p>	<p>Improve outcomes in the ICU by engaging physician and nursing leaders to:</p> <ul style="list-style-type: none"> • Share best practices. • Share clinical training resources to maximize efficiencies and standardize care. • Implement collaborative methodology to focused initiatives. 	<p>Continue to design and offer high quality educational programs to ICU clinical staff.</p> <p>Determine priorities for next phase of the CCLN Educational Series.</p> <p>Develop an initiative to focus on the early identification and rapid treatment of sepsis.</p> <p>Develop a pediatric critical care workgroup which will focus on development of a pediatric RRS and expand to family activated RRS, as well as focus on reducing CLABIs in the pediatric and neonatal ICUs.</p>	<p>Reduced and more appropriate use of ICU resources and reduced LOS through:</p> <ul style="list-style-type: none"> • Improved patient flow from ED to ICU, ICU to the floor, and ultimately to discharge.

GNYHA Quality and Patient Safety Initiatives

Improving Care and Safety, Reducing Health Care Costs, and Enhancing Efficiency

GNYHA Initiative/Partners	Description/Goals	Next Steps	Cost Savings/Benefits
<p>Rapid Response System (RRS) (38 Hospitals)</p> <ul style="list-style-type: none"> • United Hospital Fund <p>GNYHA Contact: Zeynep Sumer UHF Contact: Andrea Hoberman</p>	<p>Develop hospital systems that include designated teams of clinicians who respond to early signs of acute deterioration and bring critical care expertise to the bedside before patients decline into a critical state.</p>	<p>Analysis of code review data to identify triggers that should have initiated an RRS call – “missed opportunities.”</p> <p>Development of sustainable educational tools including RRS video.</p>	<p>Improved staff and patient satisfaction.</p> <p>Statistically significant increase in the number of RRS calls since initiation of the collaborative in 2006.</p> <p><i>Source:</i> GNYHA/UHF RRS Code Data.</p>
<p>Pressure Ulcer Improvement Collaborative</p> <ul style="list-style-type: none"> • Continuing Care Leadership Coalition (CCLC) <p>GNYHA Contact: Zeynep Sumer/Kelly Donohue CCLC Contact: Roxanne Tena-Nelson</p>	<p>The Collaborative is intended to implement the use of standardized, evidence-based clinical best practices across the continuum of care and create a sustainable approach to the prevention, assessment, management, and documentation of pressure ulcers. Through educational sessions and periodic conference calls, the Collaborative will provide members with a deeper understanding of the barriers to reducing pressure ulcer rates across settings and within the region.</p> <p>The effectiveness of the Collaborative interventions in reducing pressure ulcer rates and improving care coordination across settings will be determined through data collection and analysis.</p>	<p>The steering committee has developed a work-plan and set of interventions focused on the transition of patients across the continuum of care.</p> <p>Solicitation and application for Collaborative participation sent to interested facilities.</p> <p>“Kick-off” educational session scheduled for November 2009.</p> <p>Collaborative funding source needs to be identified.</p>	<p>According to CMS, pressure ulcers are both a high cost and high volume adverse event.</p> <ul style="list-style-type: none"> • In 2006, 322,946 reported cases of Medicare patients who had a pressure ulcer as a secondary diagnosis. • Average charge of \$40,381 per case.* • Annualized total cost of \$11 billion.** <p><i>*Source:</i> Infection Control Today 2007. <i>**Source:</i> JAMA, 2006: Preventing Pressure Ulcers.</p>
<p>Initiative to Reduce Preventable Readmissions</p> <p>UHF, CCLC</p> <p>GNYHA Contact: Lorraine Ryan/Kelly Donohue UHF Contact: Sean Cavanaugh</p>	<p>Improve the care transitions process across all settings of care.</p> <p>Identify factors that contribute to preventable hospital readmissions. Using the collaborative methodology, develop and implement best practices to reduce preventable readmissions.</p>	<p>Develop a standardized, comprehensive, transitional care process that addresses the factors that commonly lead to readmissions.</p> <p>Meeting with various stakeholder groups that can participate in a coordinated, comprehensive initiative across the continuum of care.</p>	<p>One of every five Medicare beneficiaries—about 18 percent—returns to the hospital within 30 days of discharge. Three months after discharge, a third of beneficiaries are readmitted.</p> <p>Total cost for unplanned readmissions nationally: \$17.4 B in 2004.</p> <p><i>Source:</i> Kaiser Health News May 2009.</p>

GNYHA Quality and Patient Safety Initiatives

Improving Care and Safety, Reducing Health Care Costs, and Enhancing Efficiency

GNYHA Initiative/Partners	Description/Goals	Next Steps	Cost Savings/Benefits
<p>Quality Coach Fellowship Program (40 Hospitals)</p> <ul style="list-style-type: none"> • 1199 SEIU • NYS DOH <p>GNYHA Contact: Zeynep Sumer</p>	<p>Educate front-line staff on CMS’s quality measures.</p> <p>Empower participants to play a role in improving patient care and satisfaction.</p>		<p>Improve hospital compliance with CMS quality measures to ensure highest level of Medicare reimbursement.</p>
<p>Infection Prevention Coach Training Program (35 Hospitals)</p> <ul style="list-style-type: none"> • 1199 SEIU <p>GNYHA Contact: Maria Woods</p>	<p>Assist hospitals, through training of front line staff, in improving infection prevention practices related to hand hygiene, health care worker immunizations, and environmental cleanliness.</p>	<p>Application for funding made to the New York State Health Workforce Retraining Initiative to provide a new series of training programs.</p>	<ul style="list-style-type: none"> • Overall reduction of infections. • Instills a culture of safety and improves staff satisfaction. <p>The overall annual direct medical costs of HAIs to U.S. hospitals ranges from \$35.7 B to \$45 B.</p> <p><i>Source:</i> Division of Healthcare Quality Promotion, National Center for Preparedness, Detection, and Control of Infectious Diseases, Coordinating Center for Infectious Diseases, Centers for Disease Control and Prevention March 2009.</p>
<p>Health Information Technology (HIT)</p> <p>GNYHA Contact: Zeynep Sumer/Alissa D’Amelio</p>	<p>To the extent feasible, assist member hospitals in accessing American Recovery and Reinvestment Act of 2009 (ARRA) incentive funds and avoid future penalties by:</p> <ul style="list-style-type: none"> • Ensuring flexibility and reasonable interpretations of requirements in the Federal stimulus package; • Identifying common issues and leveraging shared resources among member hospitals; • Facilitating the strategic purchasing of HIT; assisting members with ensuring “meaningful use” requirements are incorporated into vendor contracts; • Assisting members with “meaningful use” connectivity requirements; • Increasing access to capital. 	<p>Continue advocacy on federal eligibility requirements for stimulus funds.</p> <p>Develop and implement a work plan to assist member hospitals through implementation of HIT.</p>	<ul style="list-style-type: none"> • Hospitals stand to gain up to a third of their investment in HIT through incentive payments for being “meaningful users” of HIT; • Hospitals stand to lose a significant portion of their Medicare annual payment update for not being “meaningful users” of HIT. <p>HIT holds enormous potential to positively impact patient safety, patient outcomes, hospital efficiency, and even bolster hospital bottom lines.</p>

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Improving Care and Safety, Reducing Health Care Costs, and Enhancing Efficiency

GNYHA Initiative/Partners	Description/Goals	Next Steps	Cost Savings/Benefits
<p>Gap Program (63 Nurses, 8 Hospitals)</p> <ul style="list-style-type: none"> • Jonas Center for Nursing Excellence • NYS DOH <p>GNYHA Contact: Zeynep Sumer</p>	<p>Strengthen the partnership between bachelor's degree nursing programs and hospitals:</p> <ul style="list-style-type: none"> • Develop staff nurses into adjunct clinical faculty to address faculty shortages. • Improve staff satisfaction and retention. • Improve preparation of new nurses. 	<p>Evaluate the effectiveness of the GAP program.</p> <p>Convene a GNYHA CNO Advisory Panel to identify opportunities to enhance the relationship between hospitals and nursing schools.</p>	<p>Studies of nurse turnover have reported costs ranging from \$22,000 to over \$64,000 nationally per nurse; as well as 1.5 x the salary of the departing nurse.</p> <p><i>Source:</i> Advisory Board, 1999; Jones, 2005; O'Brien-Pallas et al., 2006; Stone et al., 2003; Waldman et al., 2004).</p>
<p>The Colors of Safety Across the Continuum of Care (31 Hospitals and 27 Nursing Homes)</p> <p>Continuing Care Leadership Coalition (CCLC)</p> <p>GNYHA Contact: Kelly Donohue CCLC Contact: Roxanne Tena-Nelson</p>	<p>Enhance patient safety by standardizing the color coding of specific alert conditions across the continuum of care.</p>	<p>On-going conference calls and periodic meetings to sustain the initiative and promote implementation.</p> <p>Review data to sustain improvement.</p>	<p>Reduction in potentially avoidable adverse events.</p> <p>Improved staff satisfaction and patient outcomes.</p>
<p>Root Cause Analysis Training (Over 1,450 staff trained)</p> <p>GNYHA Contact: Lorraine Ryan</p>	<p>Provide an understanding of why and how errors occur and the skills necessary to identify both the root causes and prevention strategies.</p>	<p>Application for funding made to the New York State Health Workforce Retraining Initiative to provide a new series of training programs.</p>	<p>Identification of root causes can:</p> <ul style="list-style-type: none"> • Prevent recurrence of error. • Promote redesign of systems to prevent error. • Expedite claims adjudication thus reducing the administrative expenses of malpractice claims.
<p>Communication Skills Training (30 Hospitals)</p> <ul style="list-style-type: none"> • Disclosure, Apology, and Early Offers of Compensation <p>GNYHA Contact: Lorraine Ryan</p>	<p>Develop and improve effective communication skills to accomplish meaningful disclosure, apology, and early offers of compensation, when appropriate.</p>		<p>Early offer programs can result in decreased medical malpractice claims and administrative costs:</p> <ul style="list-style-type: none"> • University of Michigan Health System—66% reduction in annual litigation expenses and 50% reduction in claims.

October 29, 2009



Testimony of the
Iroquois Healthcare Alliance
presented at the invitation of the
**New York State Senate Standing Committees
on Insurance, Health, and Codes**
regarding
Medical Malpractice Reform

by Gary J. Fitzgerald
President, Iroquois Healthcare Alliance

December 1, 2009

Good afternoon Senators Breslin, Duane, and Schneiderman and staff. I am Gary Fitzgerald, President and CEO of the Iroquois Healthcare Alliance, a membership organization representing 57 hospitals and their affiliated organizations in 31 upstate counties. IHA's membership is diverse in that it comprises 32 rural hospitals including 5 Critical Access Hospitals, and represents the smallest hospitals in the state as well as some of the largest teaching hospitals in Upstate New York. I want to thank you for conducting this public hearing on the critical issue of malpractice insurance reform. With Congress set to debate historical changes in our nation's health care system, it is a disappointment that malpractice reform is not a major part of the proposals surfacing from the House or the Senate. This lack of attention at the federal level makes it even more critical that reforms be implemented at the state level.

My colleagues from HANYS and GNYHA have given you extensive and thorough testimony as to the problems of the New York State malpractice insurance system, the cost of the current system, and its burden on hospitals and physicians. They have also presented rational solutions to reform the New York State malpractice insurance market. The Iroquois Healthcare Alliance certainly supports the recommendations made by HANYS and GNYHA, and will work with them, and with you, to see that these reforms become reality. I will not repeat their testimony, but would like to speak briefly on the effects of New York State's dysfunctional malpractice marketplace on Upstate hospitals and physicians.

Communities in Upstate New York desperately need to recruit new physicians. IHA members are struggling with recruitment of physicians – primary and specialty. Physicians of all types are needed and in short supply, and in some cases non-existent in many Upstate communities. The most recent study from the SUNY Center for Health Workforce Studies shows that the average

age of a physician in New York State is 51, and slightly older in rural counties. The aging physician population and the need for additional health care services in Upstate due to its aging general population, creates a challenging environment. The Iroquois region saw a net gain of only 97 physicians in 2007 and a need of 523 more physicians, and that need is expected to increase.

The state produces about 18 percent of the nation's physicians, more than any other state. Physicians trained in our New York City teaching hospitals are very aware of the cost of New York's malpractice insurance and what that would mean to them financially. Physicians trained in New York, and receiving offers to practice in other states, will consider New York's malpractice insurance rates when making their career decision. In a Syracuse Post-Standard article published last week, the Onondaga County Medical Society's president noted that "while New York receives a paltry 150 license applications from physicians per month, there are 2,500 applications in Texas, where malpractice reforms took effect four years ago." Reforming the state's malpractice insurance system would prove that New York State is a physician-friendly state – and that distinction would be very helpful in reducing the number of physicians we "export" at a time when Upstate is struggling to attract physicians.

And, although medical malpractice is not the only challenge for recruitment, as more of our Upstate hospitals must employ their physicians, the cost of medical malpractice has become a growing cost to hospitals. Hiring physicians is frequently cited as the only available option of bringing physicians on staff. According to a HANYS 2008 study "Access to Care in Crisis: Physicians in Short Supply," 78% percent of respondents indicated directly hiring 967 physicians in 2007. Physician employment has become an important recruitment and retention tool. The

employment of physicians by the hospitals has led to the hospitals assuming more of the cost of medical malpractice insurance of individual physicians. Malpractice reform to reduce that cost would be beneficial to hospitals that continue to struggle financially.

IHA supports proposals that improve patient safety, enhance efficiency, and reduce costs for patients and providers, and has worked with Senator Valesky to develop legislation for a demonstration program. Senator Valesky has just introduced the bill. The overall goal of the demonstration is to take a small step forward and introduce a real reform measure into the current debate on how to address New York State's worsening medical malpractice liability insurance crisis. The proposal is a demonstration program to evaluate whether overall medical malpractice costs can be reduced by the use of a model that provides that, in cases where an unanticipated outcome from the provision of health care occurs, when the facility/provider explains what has occurred, apologizes, and when the standard of care was not met, offers a financial settlement. The Sorry Works! Demonstration includes patient protections as well as hospital/provider protections. The program encourages patients to utilize counsel in Sorry Works! Program negotiations and requires the patient to affirm that nothing was done to dissuade them from obtaining counsel. Collateral source payers may not seek reimbursement of funds paid to the injured party as a result of a Sorry Works! settlement. The program makes a provision to the statute of limitations to commence a civil action to account for Sorry Works! negotiations. And, in cases where a settlement is accepted and further civil action foreclosed, this program requires the provider to participate in peer review/further root cause analysis of the unanticipated outcome.

For the hospital/provider participating in the Sorry Works! Program, if a patient accepts a settlement, all further litigation is prohibited. The apology and explanation is protected from discovery in any civil action provided such information is not otherwise discoverable. The program requires an affirmative vote of the medical staff for a hospital to be considered a demonstration site. Under the Sorry Works! Program, a settlement does not constitute a reportable malpractice claim.

In our review of the experiences of other health systems which have adopted an early apology model, there are reports and empirical evidence from health systems (University of Chicago, University of Michigan among others) that these systems had decreased litigation and associated costs, increased incident reporting and investigation, and improved patient safety.

It is our contention that the northern and central regions are optimal to conduct this demonstration based on the expressed interest of the hospitals in the region, the more moderate litigious environment, the average size of the facilities, and the relationship between the facility and the physician community. As I mentioned earlier, physicians in the IHA region are increasingly employed by the facilities closely aligning policies and goals. Even in cases where physicians are not directly employed, the frequent role of the hospital as the hub of the community's health care system most often dictates that the physicians and hospitals are tightly integrated. Finally, the overall size of the majority of the Upstate communities in relation to the health care infrastructure, usually provides for a dynamic whereby the patients are more likely to have a personal relationship with the hospital staff and be emotionally invested in the facility. This context increases the likelihood that the patient will be receptive to a model which provides for an explanation, an apology, and when indicated, compensation.

Thank you again for your time and the opportunity to comment. I hope that during your deliberations you will seriously consider the issues that I have discussed with you today. The members of the Iroquois Healthcare Alliance look forward to working with you in making sure that quality, affordable health care is accessible to all of the citizens of New York State. I am happy to respond to any questions.