

Quantifying Compliance and Quality: Understanding the Economic Impact of Inadequate Care

Today's Compliance Includes both Quality and Risk Management

Authors' Note: Beginning with this issue, we will attempt to continue the outstanding work done by Robert J. Jacoby in previous Quality of Care articles. The reader's thoughts, feedback, and comments are welcomed by the author.



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Is the delivery of quality services a concern for compliance officers and compliance programs? How can a corporate compliance program impact quality? Most of all, how do we quantify the cost of inadequate quality in a useful way that can help influence positive change in our organization?

ECONOMIC JUSTIFICATION OF COMPLIANCE AND QUALITY PROGRAMS

Health care administrators and managers are challenged to economically justify operations — by boards of directors, chief executive officers, stockholders, and financial officers. The case for economic necessity of a corporate compliance program typically has been tied to landmark compliance cases, Office of Inspector General (OIG) settlements, the potential economic impact of corporate integrity agreements (CIAs), and the need to comply with laws, regulations, and regulatory guidance.

The financial impact of OIG activity is notable. In fiscal year (FY) 2006 alone, the OIG recorded savings or recoveries of \$38.2 billion, including \$35.8 billion in implemented actions, \$789.4 million in audit receivables, and \$1.6 billion in investigative receivables.¹

But what about the economic impact of inadequate quality of care? Is it quantifiable? This article attempts to

identify the financial impact of one aspect of real or perceived inadequate quality — the cost of medical malpractice settlements and awards. Our goal is to provide quality, risk management, and compliance officers with additional information to assist their quality, compliance, and risk management improvement efforts.

QUANTIFYING THE ECONOMIC IMPACT OF POOR QUALITY OF CARE

Some organizations have attempted to quantify the macro-economic impact of inadequate quality in health care. The Juran Institute identified the cost of “outmoded and ineffective procedures” at \$390 billion after a two-year study concluded in 2002. The 88-page study argued that 30 percent of all health care spending is the result of overuse, misuse, and waste.² The economics of poor quality are clear when one considers that the Centers for Medicare and Medicaid Services (CMS) projects U.S. spending on health care is projected to equal \$4.1 trillion by 2016.³

At a recent national conference, this writer was surprised when a group was asked if they were patient safety advocates or risk managers. Three of a group of 100 identified themselves as being patient safety focused. Dismissively, the speaker went on to say that “...risk managers are concerned with the economics of risk — while patient safety advocates want to save the world.” Clearly, the group and the speaker did not make a connection between the economics of risk reduction and the improvement of quality.

Health care organizations and many managers tend to segregate operations, and related risks, into management “silos.” Conventional wisdom argues that segregation of risk allows large or complex organizations to address issues and tasks by breaking them down into manageable components. The division of tasks into segregated units of work is also a characteristic of large organizations with complex structures and strong departmental manage-

ment.⁴ This segregation of risk is working against health care organizations today, in an environment increasingly focused on improving quality of care and incorporating quality as a consideration in corporate compliance programs.

The justification for federal and state concerns over quality issues in health care is clear. The FY 2007 public advertising and education campaign of the National Institutes of Health (NIH) notes that according to the National Institute of Medicine (IOM), 120 patient deaths per day occur in U.S. hospitals due to medical errors, more than are due to motor vehicle accidents, breast cancer, or AIDS.⁵ To the public, the occurrence of medical errors equals poor quality of care.

A widespread perception of inadequate quality in health care services has been driven by widely promoted studies, highly publicized legal and regulatory actions, and an aggressive plaintiff’s bar that effectively and widely uses mass media. In the United States, patients (or families) who feel inadequate quality of care contributed to patient injury typically resort to the court system to address their anger, frustration, grief, and loss.

QUALITY REFLECTED IN PROFESSIONAL LIABILITY COSTS

Through the Data Sharing Project of the nation’s leading medical malpractice industry association, we can begin to quantify the economic impact of real and perceived inadequate quality.

In 2006, medical liability insurer American Healthcare Providers Insurance Services (AHPIS, Philadelphia, Penn.) undertook a study of medical malpractice claims data collected by the Physician Insurers Association of America (PIAA). PIAA is an association of over 60 physician insurers located across the United States, which collectively provides professional liability insurance to 60 percent of U.S. physicians. PIAA has compiled and studied claims data submitted annually by insurers since the early 1980s.

One goal of the study was to identify if common risk exposures face medical liability, compliance, and quality disciplines. Study findings were analyzed by senior staff including a board-certified corporate compliance officer and licensed health care risk manager with hospital, long-term care, and medical practice operations experience, physicians and nurses, professional liability underwriters, and claims managers. The fully developed study data was refined into specialty-specific presentations accredited with the American College of Continuing Medical Education (ACCME) for use as a risk reduction tool for AHPIS insured physicians.

The PIAA study examined the following data:

- Leading allegations listed in medical malpractice claims;
- Frequency (number of claims filed) and severity (indemnity cost);
- Average indemnity payments made for each type of allegation;
- Severity of claims filed in 2005 compared to the average of previous years; and
- Patient conditions and specific procedures or medical events identified in claims.

The data collected over a 20-year period (1985 to 2005) for all medical specialties provides a detailed assessment of the economic impact of quality of care-related claims. Importantly, many of the issues identified in the study can be addressed through components of a combined quality management/corporate compliance/risk management approach. Some issues that appear to be common to quality and compliance are as follows:

- Failures to monitor or supervise medical cases resulted in 16,430 cases with a total indemnity payout value of \$1.2 billion dollars;
- Medication errors resulted in 9,326 cases with a total indemnity payout value of \$369 million dollars;
- Procedures performed when not indicated or necessary resulted in 6,702 cases

with a total indemnity payout value of \$382 million dollars; and

- Failure to communicate with or instruct patients resulted in 4,771 cases with a total indemnity payout value of \$118 million dollars.⁶

A study of claims by associated medical or legal issues revealed the following:

- Problems with medical records accounted for 5,051 claims with a total indemnity payout value of \$603 million dollars;
- Premature discharge accounted for 2,625 claims with a total indemnity payout value of \$242 million dollars;
- Lack of adequate facilities or equipment accounted for 1,985 claims with a total indemnity payout value of \$217 million dollars;
- Improper conduct by physicians accounted for 1,943 claims with a total indemnity payout value of \$70 million dollars;
- Unnecessary treatment accounted for 1,693 claims with a total indemnity payout value of \$118 million dollars;
- Breach of confidentiality accounted for 918 claims with a total indemnity payout value of \$8 million dollars;
- Failure to conform with regulations/statutes accounted for 902 claims with a total indemnity payout value of \$68 million dollars;
- Pharmacy error accounted for 355 claims with a total indemnity payout value of \$18 million dollars; and
- Managed care referral problems accounted for 276 claims with a total indemnity payout value of \$15 million.⁷

The phrase “total indemnity payout value” refers only to the amounts paid to claimants by jury award or settlement. This does not include any associated costs, such as legal defense or lost time, which other studies have shown to be extremely costly. This study also cannot quantify the human suffering and distress associated with professional liability issues.

Taken together, these claims resulted in \$3.4 billion in indemnity payments in

52,977 medical malpractice cases resolved from 1985 to 2005 for PIAA member companies alone. Even if we assume some claims were unjustified, it is difficult to ignore an average of almost 53,000 liability claims per year.

Obviously, this data addresses the economics of cases brought against physicians. How is this data important to other health care entities? Simply put, medical malpractice cases are seldom filed against one individual or entity. In fact, the vast majority of cases are filed against all parties involved: the medical professional, the health care institution, and any ancillary providers of care or diagnosticians (such as radiologists). Each insured named in a claim may be economically impacted by the claim.

It is a common fallacy to fail to study these figures because insurance companies, not the insured, bear the majority of financial responsibility for claims. Today, most health care organizations retain a portion of the initial liability (a deductible or self-insured retention). Common retentions or deductibles range from \$25,000 to \$100,000. Some are much higher, depending on the ability of the organization to assume risk. The deductible or retention may lower insurance rates by assigning the first dollars of a claim or settlement to the insured entity.

Deductibles or retentions can affect the underwriting ratings and subsequent premiums of the insured. Professional liability premiums may make up the third largest expense of many health care organizations (behind personnel and facilities/equipment).

There is another hidden cost to health care providers. Studies conducted internally by AHPIS indicate 112 physician man hours are needed to participate in defense against one case. This does not include lost productive time associated with rescheduling cases or patient appointments previously scheduled (and now cancelled) during that 112-hour period.

Those familiar with medical malpractice defense note that notice of depositions or

court dates are not usually received with great advance warning. Usually, it is necessary for affected physicians to cancel and reschedule appointments and procedures at the last minute, resulting in greater associated costs for both the medical practice and any affected hospitals. The associated productivity and quality impact of lawsuit defense is significant.

Most risk management issues are directly related to regulatory compliance and quality of care concerns. The issues revealed by many compliance audits are surprisingly similar to those found by quality audits and malpractice risk studies. These include inadequate medical records documentation; failure to provide informed consent or patient education; and performing (and billing for) unnecessary services.

OTHER FACTORS IMPACTING QUALITY

In addition to increased demands for measurable quality improvements, most health care systems are struggling with staffing shortages and the sheer volume of patients that must be seen in order to meet demand or maintain economic viability. Patient volume increases are driven by today's older population with more co-morbidities and diagnostic needs; population growth surges in suburban areas; and the need to process larger numbers of patients more quickly in many medical services due to limited reimbursement.

Staffing concerns that lead to quality concerns are evident in current nursing staff shortages and a projected pending shortage of physicians. Current forecasts project physician shortfalls of 85,000 to 200,000 doctors by the year 2020 and project that patient demand for care at current rates will far outstrip the number of physicians who will be available in the United States by that time.⁸

CONCLUSION

Early studies by the Juran Institute (2002) place the economic cost of inadequate quality as high as \$390 billion per year in the United States. Juran Institute analysts also

project that 30 percent of all U.S. health care spending is the result of overuse, misuse, and waste.⁹

CMS projects U.S. spending on health care at \$4.1 trillion by 2016. If Juran estimates are correct, \$1.23 billion will be wasted due to poor quality.

PIAA studies identify \$3.4 billion in indemnity payments made in 52,977 medical malpractice cases resolved from 1985 to 2005. A review of PIAA claims by allegation shows that real or perceived inadequate quality of care is reflected in a variety of sources, including many areas commonly analyzed by corporate compliance programs. These include medical records documentation, informed consent and patient education, supervision of medical cases, provision of unnecessary services, premature discharge, and failure to comply with laws and regulations.

Corporate compliance programs have the ability to directly impact quality of care by identifying and limiting compliance issues that are also quality issues. The high cost of poor quality, and the potential of compliance to reduce these costs, is an added justification for the work done by effective compliance programs.

By nature of the concerns we investigate and resolve, today's compliance officers are also quality officers and risk managers. Effective risk and quality managers must be focused on quality issues that can eliminate the causes of claims rather than addressing claims retrospectively. A proactive approach by compliance, quality, and risk departments can reduce unnecessary

expense, alleviate human suffering, and improve the public perception of our organization as a quality leader.

The costly economics of poor quality compliance in health care are clear. The question we must answer is, are we willing to use this data to effect quality change in our health care organizations?

Endnotes:

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