LIAIBILITY >> Andis Robeznieks

Jumping hurdles
Some AHRQ grant ideas moving ahead

The Obama administration put $25 million on the table in October 2009 to nurture better ways to address medical liability, and House Republicans in early 2011 set about pushing caps on damages.

While the GOP’s tort reform measure appears to have hit a roadblock in the Senate after the House passed it in March, some ideas funded by the grants disbursed through HHS’ Agency for Healthcare Research and Quality are moving ahead.

A coalition of six Boston-area healthcare organizations recently unveiled a program aimed at improving the state’s medical liability system, a project seeded with a planning grant of almost $274,000 that Beth Israel Deaconess Medical Center received from AHRQ.

“We want to offer patients something other than the court system,” said Dr. Alan Woodward, a former emergency physician and the past president of the Massachusetts Medical Society. “If you reform the tort system, you still have a tort system and you’re not going to do away with the fears that lead to defensive medicine.”

Woodward is chair of the MMS Committee on Professional Liability, and he’s working to implement a “Roadmap to Reform” with a coalition that also includes Boston’s Beth Israel Deaconess, Springfield-based Baystate Health, the Massachusetts Coalition for the Prevention of Medical Errors, the Massachusetts Hospital Association, and Medically Induced Trauma Support Services, which is a support group for those affected by adverse medical events—both patients and clinicians.

The plan is to institute a program they call Disclosure, Apology and Offer, which—just as it sounds—consists of disclosing when adverse events occur, investigating why they happened, sharing that information with patients and their families and then offering financial compensation and bypassing the court system.

According to Woodward, malpractice cases in Massachusetts take five and a half years to resolve. Of the dollars physicians pay for liability premiums, he added, only 30% goes to patients, with the rest covering insurance company overhead, attorney and expert witness fees and other court costs.

“We can do better,” Woodward said. “You don’t have to have dueling expert witnesses. You can do a root-cause analysis at relatively low cost and put the findings on the table.”

The project started with structured interviews with representatives from 27 organizations or industry sectors with a stake in malpractice reform, and Woodward said everyone agreed that disclosure, apology and offer was the best strategy to adopt.

“We were surprised by the unanimity of opinion,” Woodward said. “But the overall message was: This is the right thing to do.

“It’s what you would want done if you were a patient or a family member of a patient who was harmed.” He said the coalition also studied a similar program in place for 10 years now at the University of Michigan Health System where results show it is working as intended.

The grant Beth Israel Deaconess received was part of a package of seven demonstration grants and eight planning grants totaling $23.2 million awarded in June 2010 and financed through a special congressional appropriation, said AHRQ spokeswoman Karen Migdail, adding that another $50 million package was authorized in the Patient Protection and Affordable Care Act, but the money has never been specifically appropriated by Congress.

The University of Illinois at Chicago received a demonstration grant for almost $3 million to expand its own disclosure, apology and offer program, known as Seven Pillars, to other area hospitals.

Dr. Timothy McDonald, a physician and attorney with the school and the University of Illinois Hospital & Health Science System, said the program started with five and has now grown to include 10 area hospitals—with some acting as a control group.

“We really want to do some good science here and measure whether it’s our intervention that made the difference or it would have happened anyway,” McDonald said.

Acknowledging that a large self-insured academic medical center with employed physicians may have advantages in adopting such a program, McDonald notes that the other hospitals in the demonstration are private hospitals with open medical staffs.

McDonald said the Seven Pillars program has been in place since 2006 and has prompted a “substantial reduction” in malpractice claims and premiums. But, more important, the open investigation of errors and adverse events has led to fewer incidents of patient harm, he said.

These programs are seen as alternatives to other proposed tort reforms such as caps on damages or special healthcare courts where cases are tried before medical experts instead of lay juries. Both Woodward and McDonald said it would be a long time—if ever—before either of those alternatives was adopted by their states. “In our view, there was no point in holding out for that,” McDonald said.

In the New York State Unified Court System, Judge Judy Kluger is leading a “judge-directed negotiation” program that received an almost $3 million grant from AHRQ.

“We’re really in the beginning of this,” Kluger said, explaining that the project is being evaluated by the Harvard School of Public Health, which didn’t get the go ahead to do so from its institutional review board until last September.

Participating judges underwent a three-day training session that included education on medical legal issues and mediation techniques. Kluger said the program is “not a health court.” Rather, the point is to offer an opportunity to settle before litigation gets into full swing.

The expectation, Kluger said, is that plaintiffs will get restitution earlier and defendants will get “something of a discount.” The process is designed to keep cases from getting bogged down, she said. “We make sure that there’s always a future date set where something has to happen on a case—where it moves forward or gets resolved.”

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