Washington
Healthcare Forum

A 21st Century System of
Patient Safety and Medical Injury Compensation
Executive Summary

Overview

- Our goal is to promote patient safety and reduce preventable errors and injuries.
- We want to replace our fault-based medical liability system, with a new, patient-oriented system based on prevention.
- As a result, people who suffer avoidable injuries will receive timely and fair compensation.
- Currently, most people who are harmed are not receiving any compensation and there is no organized way for the health care system to prevent future errors.
- This new system would ensure that most people who are harmed by a preventable medical error would be compensated, and that there would be fewer errors over time.

Current Situation

The Washington Healthcare Forum (the Forum) has been working for several years on a new approach to patient safety and medical injury compensation. This effort pre-dated the 2005 filing of Initiative 330.

Legislation enacted in the 2006 session began to address some of the problems with the current system. We applaud Governor Gregoire for her leadership, and members of the legislature for their support of House Bill (HB) 2292.

Highlights of the bill include:
- Physicians would be able to apologize for a medical error within 30 days without it being used against them in court.
- Mediation would be mandatory before a lawsuit could proceed.
- If both sides agree, they have the option to use binding arbitration to avoid litigation.
- Juries would be allowed to hear if an injured patient had received payment from an insurer or other source.
- Plaintiffs' attorneys would be required to have malpractice claims reviewed by a medical professional from the discipline involved in the case.

However, more work needs to be done. The Forum believes the state can build on the forward momentum established by HB 2292 by creating a new, patient-oriented system to meet 21st century needs.

Problems with the Current System

We believe the current medical liability system is fundamentally flawed and patients deserve a long term solution. Three significant problems plague the current system:

1. The system does not promote or support patient safety or the elimination of medical errors.
   - According to a Harvard Medical Practice study, "evidence of deterrence is limited and not robust across measures of malpractice risk, such as claims, perceived risk, and premiums."[1]
   - Fear of liability discourages open communications, trust, and collaboration, and fails to provide a systematic way to prevent future errors.
2. The system does not fairly compensate those who are injured
   - Researchers at Brigham and Women's Hospital and Harvard School of Public Health found no correlation between negligent care and malpractice claims.
   - According to the study's lead author, the "elderly and the poor were more likely to suffer negligence and not sue, probably because their low-income status restricted their ability to secure legal representation."
   - The study also found, "Less than one quarter of the patients who filed a malpractice claim were found to have suffered injuries caused by negligence. On the other hand, of the patients who did suffer negligent injury, 97 per cent did not sue."[2]
3. The system wastes too many resources.
   - Successful claimants receive less than half of the money available to pay an award and associated expenses.[3]
   - The system also results in unintended effects, such as defensive medicine—that is, practitioners ordering more tests or prescribing

[1] Michelle Mello, JD, PhD, "The Medical Liability System: Can it Make the Grade?," Harvard School of Public Health
[2] http://www.hsph.harvard.edu/press/releases/press03012000.html
[3] Physician Insurers Association of America, www.piaa.us/

more medications to avoid lawsuits—and avoidance of high risk patients and certain procedures.[4]

A New System Based on Prevention

We engaged nationally recognized experts to help us develop a strategy that will:

- Make sure more patients who are injured receive compensation; and
- Create a system of continuous improvement so fewer mistakes are made over time.

Our approach is oriented toward prevention and patient safety, which is very similar to national efforts such as those supported by Leapfrog and the Joint Commission on Accreditation of Healthcare Organizations.

The new system we are supporting features six interdependent elements:

1. Better prevention of medical injuries
2. Fair and faster compensation of medical injuries
3. Alternative dispute resolution (ADR)
4. A patient safety representative
5. Maintaining affordability
6. Preventing egregious conduct

1. Better prevention of medical injuries

In this new system, prevention replaces negligence as the standard for identifying and compensating medical injuries. Prevention also serves as the basis for patient safety improvements.

- There are three key elements:

  I. Preventability standard

  Experts determine the preventability of entire categories or types of injuries in advance: Avoidable Classes of Events or ACEs. Experts agree in advance that ACEs are statistically preventable as a class. When an ACE occurs, the injured patient does not need to prove a right to compensation.

  ACEs will make it easier for patients and providers to recognize a compensable injury; simplify the decision-making process; and make results more consistent and credible. Other injuries also should be evaluated by prevention standards.

  II. Proactive case identification

  ACEs and the prevention standard promote new behavior. Disclosure becomes less painful for providers as contentious lawsuits are replaced with prevention

[4] Harvard School of Public Health Project on Medical Liability in Pennsylvania, 2004.

standards. Professional associations should encourage proactive case identification, and public oversight could support this critical process.

III. Using data to prevent injuries

Providers would get data on avoidable injuries and improve patient safety. Compensation data and other information would be used to create systemic interventions and measure their effectiveness. Insurance determines how to organize and rate providers to cover the risk of ACEs and other preventable injuries.

2. *Fair and faster compensation of medical injuries*

Patients with preventable medical injuries do not bear out-of-pocket health care costs. All compensation sources are coordinated. Compensation for pain and suffering is standardized and proportional to the length and severity of effects. Compensation would be structured to pay net out-of-pocket costs of covered losses— such as medical expenses, wage loss, and other reasonable costs—and a schedule would be developed for non-monetary losses.

Structuring Compensation for Predictability and Consistency

- *Basic standard:*
  - Pay net out-of-pocket costs of covered losses—medical, wage-loss, and other reasonable costs
  - Schedule any allowances for non-monetary losses, based on severity and duration of injury
- *Further design issues:*
  - Whether to pay in advance for future losses or pay as they occur
  - How to standardize estimates of current value of future losses

3. *Alternative Dispute Resolution*

In this new system, most ACEs and other preventable injuries will be resolved voluntarily, including through mediation. Injured patients and their providers may sometimes still disagree in three areas:

- Whether or not a particular injury is compensable as an ACE;
- Whether a non-ACE qualifies under the general standard of preventability; or
- Whether the amount of compensation offered is reasonably related to losses already suffered or yet to come.

Alternative dispute resolution will serve as the fall-back mechanism to handle cases not resolved under the basic ACE- and disclosure-based processes. Alternative dispute resolution can help to resolve disagreements more fairly and quickly than litigation.

Possible alternative dispute resolution options include: mediation, private arbitration, medical courts, or an administrative agency similar to workers' compensation.

Regardless which model is used it should be based on the following guiding principles:

- Efficient
- Economical
- Accurate
- Consistent
- Concentrated expertise
- Coordinated feedback for learning

4. A patient safety representative

A new kind of patient safety representative could help injured patients navigate the new process, especially in cases that do not clearly qualify as ACEs or where profound injuries occur. Patient safety representatives will work collaboratively toward solutions that could include non-monetary remedies, such as explanations and patient safety improvements. The representatives will be motivated to use lawyers' services only where lawyers add value, so that adjudication serves the compensation system as opposed to driving it.

5. Maintaining affordability

The cost of the new system can be reduced and controlled in a number of ways, including:

- Reducing the administrative overhead from faster claim resolution and fewer disputes;
- Reducing the number of invalid claims made and paid;
- Aligning incentives to report, dropping "blame," and creating transparency on compensation, such as schedules for non-economic damages and a pre-set discount rate for future inflation, should create trust and provide value;
- Improving coordination of benefits with non-liability payers such as insurance and disability coverage; and
- Adjusting the rules and requirements of the new compensation system to keep the system affordable.

Feasibility studies should test these assumptions and adjust standards as needed. A pilot study could be designed to allow patients and providers to opt-in to the system before an injury occurs, and test and refine various elements of the proposal. Building a solid, affordable foundation is essential to the long term viability of the new system.

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6. Preventing egregious conduct

A strong, workable, fair approach for disciplining bad practitioners is an essential component to a new system. Effective oversight and discipline must address the behavior of the small subset of "bad-apple" practitioners who do not comply with safety processes and rules. Discipline should be enhanced through institutional peer review, state medical boards, or some alternative. Stronger relationships between state licensure boards and other quality monitors, along with caregivers and safety analysts, will support this effort as well.

Our proposal does not address medical discipline in the depth we feel necessary. However, we have deferred further work in this area pending recommendations from Governor Gregoire's initiative on medical discipline.

Resolving Cases in the New System

The Governor appoints an expert panel, including individuals with national credentials and medical clinical expertise, ethicists, consumer representatives, and economists. The panel oversees development of the initial ACE list. The panel might contract with a neutral, well-respected research organization to help develop the initial list. Possible organizations include:

- RAND
- Institute for Healthcare Improvement
- National Quality Forum

The panel would hold public hearings on proposed ACEs and approve an initial list. The panel also would be responsible for:

- Determining a schedule for non-economic damages;
- Setting parameters or formulas for economic damages; and
- Updating the ACE list quarterly and incorporating additional classes of events over time.

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Patient Oriented System's Process for Decision Making

Unexpected bad outcome

ACE?

Yes

No

(Provider determines proactively)

Offer compensation

Prevent-able?

Yes

(Patient & representative determine after appropriate mediation)

No

Accept?

Patient doesn't agree with provider

Patient agrees with provider

Yes

No

Compensation

Dispute resolution

Jury trial negligence standard

End

Judicial review of process

Examples of potential Avoidable Classes of Events or ACEs include[5]:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgical procedure performed on a patient
- Object left in patient after surgery
- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics
- Patient death or serious disability associated with the misuse or malfunction of a device
- Infant discharged to the wrong person
- Patient death or serious disability associated with a medication error
- Patient death or serious disability associated with transfusion of blood or blood products of the wrong type
- Death or serious disability associated with failure to identify and treat hyperbilirubinemia, a blood abnormality, in newborns
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a burn incurred in the hospital
- Patient death or serious disability associated with the use of restraints or bedrails

How the New System Would Work

- An unexpected bad outcome occurs.
- The provider determines that it's either an ACE or a preventable injury.
- The provider apologizes and explains economic and non-economic compensation available under the guidelines.
- A patient advocate is available for the injured party.
- There is an opportunity for the patient and provider to discuss the offer.
- If no agreement is reached, the dispute moves to mediation.
- If mediation doesn't produce an agreement, the case would move to a binding alternative dispute resolution, such as a medical court, binding arbitration or an administrative agency.

[5] Referenced in Washington State House Bill 2292 and included in "*Serious Reportable Events in Healthcare*," 2005-2006 Update, National Quality Forum

- Judicial review of the process would be available, as needed, to assure patients of a fair outcome.
- If an incident were determined by the provider not to fall under the preventability standard, and if the patient disagrees with that finding, the patient would have a choice. The patient either could stay with the alternative dispute resolution process, or use the current tort system under the negligence standard.

Next Steps

Because this approach is a wholesale change in focus, we recommend testing and refining the various elements with feasibility studies, followed by pilot projects. Hospitals, integrated delivery system, academic medical centers, or multi-specialty group practices could create an opt-in approach for patients and providers. As a safety mechanism, injured parties would have access to some form of judicial review after they went through the process.

This pilot approach is consistent with the 2003 Institute of Medicine report, "*Fostering Rapid Advances in Healthcare.*"

Design and Implementation Issues

The following are the next steps needed to move toward a patient-oriented medical-injury system:

- Develop preventability standards for medical injuries:
  - ACEs and the process for creating and approving them for use
  - Rules for case-by-case determinations for non-ACEs
- Create compensation standards; need to weigh tradeoffs, especially on future losses and non-monetary compensation
- Choose a mix of ADR mechanisms to be available; develop them for implementation
- Determine the desirability of new patient representatives, flesh out provisions
- Create incentives and mechanisms for productive use of new data to improve safety
- Participate in development of Governor Gregoire's egregious conduct initiative
- Design new system funding flows, with attention to insurability and overall affordability
- Design and conduct preliminary feasibility study, with retrospective review
- Conduct an opt-in pilot project to test and refine system elements
- Consider other phasing and implementation issues

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End Results of Reform

Over time, a comprehensive overhaul of our medical liability system will greatly benefit all Washington residents as:

- The system will support continuous safety improvements.
- Fewer preventable medical injuries will occur.
- Compensation will go to a greater share of patients with preventable injuries—faster, more consistently, and more cost-effectively.
- The system will be sustainable over time, and its costs will be more predictable.
- Accountability and perceptions of accountability for preventable medical injuries will be improved.
- Patients and providers will trust the system to produce good outcomes and to treat them respectfully and fairly.
- Discipline of bad or dangerous doctors will be strengthened.

About the Forum

The Forum is a coalition of health plans, physicians, hospitals, and purchasers, that has joined together to improve the health care system. Our *vision* is an efficient and effective healthcare financing and delivery system that satisfies the needs and concerns of all patients, providers, health plans, and purchasers.

Our *mission* is to:

- Streamline and simplify healthcare financing and delivery across the state
- Advance a public dialogue on sustainable solutions to the challenges facing the health care system

Our members include three local leading health plans, two statewide provider associations, a statewide health plan association, two leading health systems, physicians, health care executives, and purchasers. For more information, go to www.wahealthcareforum.org, or contact Don Brennan, chair, dbksb@msn.com.