



Press Release

Advancing Excellence in Health Care

FOR IMMEDIATE RELEASE
Friday, June 11, 2010

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HHS ANNOUNCES PATIENT SAFETY AND MEDICAL LIABILITY DEMONSTRATION PROJECTS

Funds Allocated to Develop, Implement, and Evaluate Patient Safety Approaches and Medical Liability Reform Models

Largest federal investment connecting medical liability to quality

The Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) today announced grants to support efforts by States and health systems to implement and evaluate patient safety approaches and medical liability reforms. The demonstration and planning grants are part of the patient safety and medical liability initiative that President Obama announced during a September 9, 2009 address to a joint session of Congress.

As part of his vision for a health care system that puts patient safety first and allows doctors to focus on practicing medicine, the President directed the Secretary of HHS to help States and health care systems test models that: (1) put patient safety first and work to reduce preventable injuries; (2) foster better communication between doctors and their patients; (3) ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and (4) reduce liability premiums.

Overall funding for the initiative is \$25 million, with \$23 million allocated to grants and \$2 million allocated to a final evaluation contract. The HHS Patient Safety and Medical Liability initiative supports the following:

- **Grants to jump-start and evaluate efforts.** Three-year grants of up to \$3 million to States and health systems for implementation and evaluation of patient safety and medical liability demonstrations.
- **Planning grants.** One year grants of up to \$300,000 to States and health systems in order to plan to implement and evaluate patient safety and medical liability demonstrations.
- **Review of existing initiatives.** In December 2009, AHRQ issued a review of reforms to the medical liability system and their impact on health care quality, patient safety, and medical liability claims.

Agency for Healthcare Research and Quality

U.S. Department of Health and Human Services

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“This new research is the largest government investment connecting medical liability to quality and aims to improve the overall quality of health care,” said HHS Secretary Kathleen Sebelius.

Some of the reforms that are being planned and tested under HHS’s initiative address limitations of the current medical liability system – such as costs, patient safety, and administrative burden for doctors. Grants support the creation of a judge-directed negotiation program, the development of “safe harbors” for state-endorsed evidence-based care guidelines, and early disclosure and offers of prompt compensation.

Another component of the initiative is an evaluation of improvements in both patient safety and medical liability systems. The evaluation is designed to develop the evidence base that will inform long-term solutions to the medical liability problem. This evaluation project was awarded to JBA/RAND for \$2 million.

“The goals of the HHS Patient Safety and Medical Liability initiative are widely supported throughout the health care system, and we solicited broad-based input to ensure that it reflects the needs of stakeholders,” said Carolyn M. Clancy, M.D., AHRQ director. “The projects we have funded help create measurable differences in the safety of health care for patients and help bring rationality and fairness to our medical liability system.”

The funded projects are:

Planning Grants:

Lynn Marie Crider, J.D., Office for Oregon Health Policy and Research, Portland, OR \$299,458

Richard David, M.D., John Hopkins University, Baltimore, MD, \$293,225

Dianne Garcia, J.D., Multicare Health System, Tacoma, WA, \$291,810

Wendell Hoffman, M.D., Sanford Research, Sioux Falls, SD, \$294,137

Elizabeth Guenther, M.D., M.P.H., University of Utah, Salt Lake City, UT, \$299,999

Karen Domino, M.D., M.P.H., University of Washington, Seattle, WA, \$295,837

David Baker, Ph.D., Carilion Medical Center, Roanoke, VA, \$280,924

Kenneth Sands, M.D., M.P.H., Beth Israel Deaconess Medical Center, Boston, MA, \$273,782

Nicoletta Tessler, M.A., Psy.D., Jackson Memorial Hospital, Miami, FL, \$299,576

Cynthia Shellhaas, M.D., M.P.H., Ohio State University, Columbus, OH, \$187,437

John Buckley, M.D., Wishard Health Services, Indianapolis, IN, \$154,124

Cindy Lou Corbett, Ph.D., Washington State University, Pullman, WA, \$298,810

Steven Crane, M.D., NC State/Department HHS, Raleigh, NC, \$297,710

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Demonstration Grants:

Timothy McDonald, M.D., J.D., University of Illinois at Chicago, IL, \$2,998,083

Stanley Davis, M.D., Fairview Health Services, Minneapolis, MN, \$2,982,690

Eric Thomas, M.D., M.P.H., University of Texas Health Science Center, Houston, TX,
\$1,796,575

Ann Hendrich, M.S., R.N., F.A.A.N., Ascension Health System, St. Louis, MO, \$2,990,612

Thomas Gallagher, M.D., University of Washington, Seattle, WA, \$2,972,209

Judy Kluger, J.D., New York State Unified Court System, New York, NY, \$2,999,787

Alice Bonner, M.S., APRN, BC, Massachusetts State Department of Public Health, Boston, MA,
\$2,912,566

For details on each project go to: www.ahrq.gov

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The HHS Patient Safety and Medical Liability Initiative

On September 9, 2009, President Obama addressed a joint session of Congress to announce his proposals for health insurance reform. In his speech, the President highlighted the need to invest in new ways to address medical liability claims. The President stated:

I don't believe malpractice reform is a silver bullet, but I've talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs. So I'm proposing that we move forward on a range of ideas about how to put patient safety first and let doctors focus on practicing medicine. I know that the Bush administration considered authorizing demonstration projects in individual states to test these ideas. I think it's a good idea, and I'm directing my Secretary of Health and Human Services to move forward on this initiative today.

Implementing President Obama's Vision

In October 2009, the Secretary of Health and Human Services (HHS) launched a Patient Safety and Medical Liability initiative and announced the availability of \$25 million in funding to address four goals:

- Put patient safety first and work to reduce preventable injuries;
- Foster better communication between doctors and their patients;
- Ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and
- Reduce liability premiums.

Overview of HHS Patient Safety and Medical Liability Initiative

This initiative includes the following components:

Grants to jump-start and evaluate efforts. Three-year grants of up to \$3 million to States and health systems for implementation and evaluation of patient safety and medical liability demonstrations.

Planning grants. One year grants of up to \$300,000 to States and health systems in order to plan to implement and evaluate patient safety and medical liability demonstrations.

Review of existing initiatives. In December 2009, AHRQ issued a review of reforms to the medical liability system and their impact on health care quality, patient safety, and medical liability claims.

Projects Funded by the Patient Safety and Medical Liability Initiative

HHS's Agency for Healthcare Research and Quality (AHRQ), which is administering the initiative, issued two funding announcements requesting applications for planning and demonstration grants in October 2009. All proposals submitted under this initiative by the January 2010 deadline underwent rigorous peer review by independent, scientific experts.

The awards announced on June 11, 2010 will support 20 projects designed to plan, implement, and evaluate reforms that address limitations of the current medical liability system, such as costs, patient safety, and administrative burden.

Planning Grants

The planning grants give States and health systems the opportunity to create detailed plans for patient safety and medical liability reform. AHRQ funded 13 planning grants for a total amount of \$3.5 million.

These 13 grants represent a variety of models that meet one or more of the patient safety and medical liability reform goals, including 11 that are intended to reduce preventable medical injuries in a variety of ways. The planning grants include:

- Supporting the development of a "safe harbor" for physicians who can prove they followed state-endorsed evidence-based care guidelines (1);
- Promoting shared decision making (1);
- Supporting early disclosure and offer models, which inform injured patients and families promptly, and make efforts to provide prompt compensation (3); and
- Promoting transparency and enhanced communication between providers and patients when avoidable injuries occur (4).

For details on each funded planning grant, go to: <http://www.ahrq.gov>.

Demonstration Projects

The demonstration grants support the implementation and evaluation of evidence-based patient safety and medical liability projects. AHRQ funded seven demonstration grants for a total amount of \$19.7 million.

These seven grants include a variety of models that meet one or more of the patient safety and medical liability reform initiative goals, including:

- Reducing preventable harms (6);
- Informing injured patients promptly, and making efforts to provide prompt compensation (5); and
- Promoting early disclosures and settlement, through a court-directed alternative dispute resolution model (1).

For details on each funded demonstration project, go to: <http://www.ahrq.gov>.

Overall Evaluation

The Patient Safety and Medical Liability initiative includes a competitively awarded evaluation contract, awarded to JBA/RAND for \$2 million dollars, focusing on improvements in both patient safety and medical liability systems. The evaluation is designed to allow long-term assessment of findings from multiple grants across the entire initiative.

Background Facts on Patient Safety and Medical Liability

Too many patients experience significant challenges with health care quality and patient safety, and many injured patients are not well-served by the current medical liability system.

- According to the Institute of Medicine (IOM) report *To Err is Human*, between 44,000 and 98,000 patients die each year from medical errors.
- Patients who are seriously harmed from medical errors often wait too long for compensation.
- Many experts believe fear of liability is a substantial barrier to the development of transparent and effective patient safety initiatives in hospitals and other settings.

The medical community reports serious problems with the medical liability system.

- Many doctors believe that medical liability concerns lead to “defensive medicine,” which in turn may contribute to higher costs.
- Many physicians continue to struggle to pay their medical malpractice premiums, which vary tremendously by specialty and by state. The cost of insurance continues to be one of the highest practice expenses for some specialties.
- Fears of medical malpractice claims may lead to altered practices, restricted emergency coverage, and limited or discontinued high-risk procedures.
- The evidence regarding the impact of prior efforts to reduce the occurrence of lawsuits and improve patient safety is mixed. In particular, evidence regarding the impact of specific medical liability reforms on health care quality and patient safety is almost nonexistent; these grants will address that essential gap.

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Demonstration Grants

Timothy McDonald, M.D., J.D., University of Illinois at Chicago, IL, \$2,998,083

The project is designed to fill the evidence gap regarding the impact on patient safety and litigation rates of programs that feature improved communication with patients, transparency, disclosure of adverse events, early offers of compensation, and learning from mistakes. It will evaluate the impact on patient safety and medical liability outcomes of extending an existing disclosure program from an academic hospital setting to diverse hospitals in the greater Chicago area.

Stanley Davis, M.D., Fairview Health Services, Minneapolis, MN, \$2,982,690

The objective of this project is to improve perinatal (the period prior to and just after birth) patient safety and demonstrate the relationship between improved patient safety and a reduction in the number of malpractice claims. The project will implement and evaluate the use of perinatal best practices in 16 hospitals to assess the impact on patient safety and the level of malpractice activity. This initiative builds on the institution's prior efforts as part of a nationwide collaborative to eliminate preventable perinatal harm.

Eric Thomas, M.D., M.P.H., University of Texas Health Science Center, Houston, TX, \$1,796,575

The project will review the use of a disclosure and compensation model, which informs injured patients and families promptly and makes efforts to provide prompt compensation. It will identify best practices for using disclosure to improve patient safety, and disseminate best practices to serve patients' needs and improve safety for subsequent patients. The project will investigate disclosure and compensation in the UT system over a three-year period, identify best practices for using disclosure to improve patient safety, and disseminate best practices with a focus on incorporating patient and family input into efforts to understand why errors occur.

Ann Hendrich, M.S., R.N., F.A.A.N., Ascension Health System, St. Louis, MO, \$2,990,612

This project will focus on ways of improving both the quality of perinatal (the period prior to and just after birth) patient care delivery and the way adverse perinatal events are managed in five geographically dispersed hospitals. The project will establish a uniform, evidence-based obstetrics practice model based on the idea that eliminating variation in obstetrics practice will translate to improved patient safety.

Thomas Gallagher, M.D., University of Washington, Seattle, WA, \$2,972,209

The project creates a statewide initiative involving communication training for health care workers and a collaboration between hospitals and a malpractice insurer to improve adverse event analysis, disclosure, and compensation. The goal is to enhance the culture of health care communication in order to improve patient safety and decrease medical malpractice liability.

**Judy Kluger, J.D., New York State Unified Court System, New York, NY,
\$2,999,787**

This project aims to protect obstetrical and/or surgery patients from injuries caused by providers' mistakes and reduce the cost of medical malpractice through the use of an expanded and enhanced Judge-Directed Negotiation Program currently used in New York's courts, coupled with a new hospital early disclosure and settlement model.

**Alice Bonner, M.S., APRN, BC, Massachusetts State Department of Public Health,
Boston, MA, \$2,912,566**

The project proposes to engage clinicians, patients, malpractice insurers, and the state public health agency to ensure more timely resolution of medical errors that occur in outpatient practices and improve communication in all aspects of care. The project will identify key areas contributing to ambulatory medical errors and malpractice suits in order to redesign systems and care processes to prevent, minimize, and mitigate such errors in a group of Massachusetts primary care practices. The project will also transform communication culture, processes, and outcomes in these practices so that they are more patient and family-centered, particularly with respect to proactively seeking out, handling, and learning from patients' safety experiences, concerns, and complaints.

Planning Grants

Lynn Marie Crider, J.D., Office for Oregon Health Policy and Research, Portland, OR, \$299,458

This project will develop and implement a method for setting priorities for developing evidence-based practice guidelines, craft a broadly supported safe harbor legislative proposal that will define the legal standard of care, and develop a plan to evaluate the effectiveness of the legislative proposal, if enacted.

Richard David, M.D., Johns Hopkins University, Baltimore, MD, \$293,224

This project will develop a measurement and analysis system to monitor the quality of care at hospital discharge to identify safety concerns and improve patient safety, and to alert Johns Hopkins leaders in real time of events that place the health care organization at risk for malpractice claims and to identify patient safety problems.

Dianne Garcia, J.D., Multicare Health System, Tacoma, WA, \$299,985

The project will develop a plan for implementing an integrated medical liability and patient safety program based on identifying avoidable patient safety problems, and providing an acknowledgement, apology, and standardized compensation to patients who have been harmed or their families.

Wendell Hoffman, M.D., Sanford Research, Sioux Falls, SD, \$299,995

This project will develop the infrastructure for implementing a patient advocacy reporting system throughout a multi-state, multi-facility system. This would include improving the collection of information on patients' and families' concerns about their care and identifying the parts of the system and individual physicians with disproportionate risk for unsafe care and possible lawsuits.

Elizabeth Guenther, M.D., M.P.H., University of Utah, Salt Lake City, UT, \$300,000

This project will implement and evaluate a system-wide evidence-based, ethical, and legally sound policy on disclosing safety issues and other unanticipated outcomes of care. The goal is to develop a standardized protocol that will be used for disclosure of these events to patients and their families.

Karen Domino, M.D., M.P.H., University of Washington, Seattle, WA, \$299,071

This project will develop and implement patient-friendly shared decision-making tools and processes for patients undergoing orthopaedic surgery in the University of Washington Health Care System. Shared decision-making improves patient safety by enhancing patient understanding and empowering patients to actively participate in the care.

David Baker, Ph.D., Carilion Medical Center, Roanoke, VA, \$296,610

The project examines how improved teamwork—through better communication among providers, patients, and patients' families—can improve the quality of obstetrical care and patient safety and reduce risk and liability claims.

Kenneth Sands, M.D., M.P.H., Beth Israel Deaconess Medical Center, Boston, MA, \$300,000

The main goal of the project is to develop a roadmap for implementation of a “disclosure-and-offer” patient safety initiative in Massachusetts, which may be applicable to other states. The ultimate goal is to create a new medical liability system that improves patient and provider trust, reduces fear, and improves patient safety.

Nicoletta Tessler, M.A., Psy.D., Jackson Memorial Hospital, Miami, FL, \$299,576

This project will develop and pilot a model to reduce patient suicides and suicide attempts at its health system by focusing on staff training, patient care, environmental safety, and incident reporting. The project is also designed to gather information through surveys and focus groups from internal and external stakeholders to generate recommendations of how medical liability can be restructured to improve the production and use of information about quality and safety.

Cynthia Shellhaas, M.D., M.P.H., Ohio State University, Columbus, OH, \$186,214

This project will plan an effective state-wide pregnancy-associated mortality review (“PAMR”) system in Ohio and develop comprehensive, coordinated statewide recommendations with short- and long-term, evidence-based interventions focusing on patient safety to address maternal mortality and disparities. PAMR is a good example of a process where a focus on patient safety and prevention of adverse events could lead to improvement in both health care system operations and clinical care. This could, in turn, decrease the potential for medical liability claims.

John Buckley, M.D., Wishard Health Services, Indianapolis, IN, \$154,124

The project will collect, analyze, and evaluate data regarding Wishard Health Services’ Claims Management Model to promote open communication and identify risk-prone areas, ultimately increasing patient safety by removing risks early.

Cindy Lou Corbett, Ph.D., Washington State University, Pullman, WA, \$298,810

This project will use stakeholder focus groups to design best practice medication risk management systems that can be integrated into transitional care. Upon successful completion, researchers expect to demonstrate that they can integrate medication risk management efforts into transitional care models to maximize safety, quality, and cost-effectiveness while reducing medical liability.

Steven Crane, M.D., NC State/Department HHS, Raleigh, NC, \$297,710

The goal of this project is to better understand the barriers, facilitators, and results of implementing a near-miss reporting and improvement tracking system in primary care. This project will also explore the potential of using near-miss events to increase providers’ confidence and experience disclosing errors to patients, and to determine whether these disclosures decrease the likelihood that patients seek legal advice and file malpractice claims.