Health Systems Transformation Team

AGENDA

Wednesday, March 9, 2011
Willamette University
Putnam University Center, Cafeteria
6:00 pm to 9:00 pm

Public listen-only conference line – Dial: 877-455-8688, Participant code: 915042

#	Time	Item	Presenter
1	6:00	Welcome and agenda review	Bruce Goldberg Mike Bonetto
2	6:05	Medical Liability: Oregon Health Policy Board Task Force **For Task Force report and recommendations, go to** OHPB Medical Liability Task Force Report	OHPB Board Member: Chuck Hoffman, MD Taskforce Co-Chair: J. Michael Alexander, JD
3	6:35	Review of feedback on Legislative Concept for Health System Transformation	Bruce Goldberg Mike Bonetto
4	6:45	Small group break out: Legislative Concept	Diana Bianco and facilitators
5	8:00	Report out and large group discussion	Bruce Goldberg, Mike Bonetto Diana Bianco
6	8:50	March 16 agenda	Bruce Goldberg, Mike Bonetto
7	9:00	Adjourn	Bruce Goldberg, Mike Bonetto

Next Meeting:
Wednesday, March 16th, 2011
Note:
Cherry Avenue Training Center
3414 Cherry Avenue, Suite 150
Mt. Mazama Room
Keizer, OR 97303
6:00 pm to 9:00 pm

Health System Transformation Team
Minutes
March 2, 2011
Willamette University
Putnam University Center
6:00 PM to 9:00 PM

Item
Welcome and agenda review (6:05 PM) o Mike Bonetto reviewed the timeline for the remaining scheduled meetings.
Summary of metrics discussion; Summary of regulation barriers feedback; Next steps Tina Edlund gave a presentation summarizing previous discussions and feedback on metrics and on regulation barriers. The presentation can be found here.
Community Activities: Examples to build on The team saw presentations on community examples of integrated care organizations in Oregon. • The first was given by Terry Coplin, Kay Metzger, and Bruce Abel (Program Manager of Lane Care) on the Institutional Special Needs Program in Lane County, as well as their efforts to coordinate and integrate between various agencies and providers. The presentation can be found here. • The second was given by Megan Haase and Ken Provencher on behavioral health integration. A pilot program set up primary care in a team based model, with an initial target population of fifty high cost, high usage Medicaid patients. The presentation can be found here. • The third was given by Jeff Heatherington, President of FamilyCare. FamilyCare has been an integrated physical and mental health plan since 1997.
Transformation Potential - **Health Policy Board Action Plan** Mike Bonetto reviewed the work of the Oregon Health Policy Board (OHPB), noting that this Team did not simply arrive where they are by accident. There was significant deliberation, public and stakeholder input, and staff work done as part of the work of the OHPB. The Policy Board's Action Plan for Health provided a framework which this Team has been working on refining and detailing. - **Savings Potential** Gretchen Morley (Oregon Health Policy and Research) gave a presentation on the potential savings that could result from health systems transformation. OHPR looked at a number of areas where national experts agree that savings can be found. The inefficiencies, for this presentation, were grouped into 3 areas: preventable conditions and avoidable care; unwarranted use of services; and service delivery inefficiencies. The presentation can be found here and the handout that accompanied the presentation can be found here starting on page 26. - **Questions and Discussions** • This sounds a lot like managed care of the 1980's. One response to that is that in the 1980s, there was really only one metric – financial. Today, our metrics represent a much different set of outcomes.

- Is Tort reform off the table? No – and this is not an either/or situation. Nothing is off the table.
- Evidence suggests that there is as much underutilization of necessary treatments as there is overutilization of unnecessary treatments. That is an important thing to remember. Through a value-based benefit system, the incentives will, in theory, be aligned so that those necessary treatments will be used at the right time.
- Managed care (of the 1980s) actually did work – the problem was that it inconvenienced people and health plans decided to return to patient directed care. But there are integrated models that do work, and have been scaled up. Seattle's GroupHealth Cooperative is a good example. The bottom line is that at the end of this legislative session, 20% will be taken out of the Medicaid system, period. The question is, what are we going to do about it? How are we going to provide a net and minimize the impact of these cuts?

Drafting a Legislative Concept

Mike Bonetto provided a summary of a draft of a legislative concept. The draft can be found here.

The LC incorporates the input that has been gathered thus far. It focuses on integration, coordination, local accountability, and patient centeredness. It also designates and defines an Accountable Care Organization as "a single integrated organization that accepts responsibility for the cost within its global budget and for delivery, management
and quality of the full continuum of care delivered to the specific population enrolled with the ACO."

Mike emphasized that this is just a starting point. It is *not* the final product. Over the next week we will be soliciting as much feedback on it as possible, and next week we will discuss changes.

A discussion about **Tort Reform** followed, and will be continued at next week's meeting. Bruce Goldberg reemphasized that the idea is not off the table.

Workplan review, next week (8:30 PM)

Thank you, great work, and we will see you next week.

Next meeting:

March 9, 2011
Willamette University
Putnam University Center
6:00 PM to 9:00 PM

Fact Sheet on Medicare and Medicaid Services for Dual Eligible Individuals

Dual eligible individuals have coverage under both the Medicare and Medicaid programs. Medicare is the primary payer for things covered under both programs.

Summary of Coverage in Medicare and Medicaid

Medicare

Part A - Hospital services, nursing facility services (up to 100 days), ambulance, home health and hospice
Part B - Physician and professional services, including diagnostic services, renal dialysis, and other services
Part D - Prescription drugs

Medicaid in Oregon

- Supplements Medicare coverage for low income beneficiaries, paying for certain services not covered by Medicare such as:
  - Some prescription drugs not covered by Medicare
  - Dental care
  - Eye glasses and hearing aids
  - Non-emergency transportation
- Pays for Long-Term Care nursing facility services (and alternatives including home and community-based services)
- Pays Medicare's beneficiary cost-sharing (20% for most services, more for mental health)
- Pays Medicare's Part B premium

MedicareAdvantage Plans

A MedicareAdvantage plan provides both Medicare Part A and B covered services and some additional services or lower cost sharing than traditional Medicare to individuals who choose to enroll in them. The Medicare program pays the plan to provide Part A and B services; beneficiaries who enroll in the plans usually pay premiums in addition to the Part B premium.

Special Needs Plans

A Special Needs Plan is a special type of MedicareAdvantage plan that serves Medicare beneficiaries with more intensive needs. Plans enroll people in institutional care settings, people with severe and disabling chronic conditions, or dual eligible individuals. Congress authorized them hoping that the plans would develop more robust care management strategies and would coordinate Medicare and Medicaid services. Plans separately contract with Medicare and Medicaid and beneficiaries separately enroll in Medicare and Medicaid plans.

Demographic Profile of Dual Eligible Individuals[i]

- All dual eligible individuals are disabled, legally blind, or age 65 or older
- Their incomes do not exceed about 225% of the federal poverty level (3 times SSI)
- At least 54% are age 65 or over; 42% are age 70 or over
- 62% are women
- 82% are Caucasian

Enrollment of Dual Eligible Individuals

Total number of dual eligible individuals: 59,000[ii]
Dual eligible individuals receiving long-term care services: 24,000 (41% of all duals)[iii]

Managed Care Participation of Dual Eligible Individuals

Dual Eligible Managed Care Enrollment (2011)[iv]

In both a managed Medicare plan and a managed Medicaid plan	23,000	39%
In fee-for-service for both Medicare and Medicaid	18,000	31%
In managed Medicare and fee-for-service Medicaid	5,000	8%
In fee-for-service Medicare and managed Medicaid	13,000	22%
Total	59,000	100%

Medicare Enrollment (2011)

MedicareAdvantage Special Needs Plans	18,000[v]	31%
Other Medicare managed care plans	10,000[vi]	17%
Fee-for-service	31,000	52%

Medicaid Enrollment (2011)

Fully capitated health plan or PCCM	36,000	61%
Fee-for-service	23,000	39%

Oregon MA Special Needs Plans (from largest to smallest dual enrollment in the SNP) [vii]

CareOregon
Marion Polk Community Health Plan
Lane IPA/Trillium
Atrio Health Plans (Douglas IPA)
Intercommunity Health Network (Samaritan)

Some other Oregon MA Plans that enroll dual eligibles in both MA and Medicaid plans (from largest to smallest dual enrollment in the Medicaid plan) [viii]

Providence
COIHS
Kaiser Permanente

Cost of Care and Services

Medicare and Medicaid Health and Long-term Care Spending for Duals for 2 years

Enrollment	Medicaid Health Benefit (09-11)[ix]	Long-Term Care Benefit (09-11)[x]	Medicare except Nursing Home Care (estimate)[xi]	Medicare Nursing Home Care (estimate)[xii]	Total Cost
59,000[xiii]	$300 mil TF	$1,400 mil TF	$1,970 mil	$230 mil	$3,900 mil

Endnotes:

[i] Source: DMAP DSS data warehouse, Jan 15, 2011.

[ii] Source: DHS December 2010 rebalance and January 15, 2011 FCHP/PCCM/FFS Enrollment, rounded to nearest 1,000.

[iii]Source: Senior and Disabled Services data run March 7, 2011, rounded to nearest 1,000. Same as fall 2010 caseload forecast for 09-11. Note: Of the approximately 28,000 individuals receiving long-term care services, 85% are dually eligible.

[iv] Source: DMAP DSSURS data warehouse, Jan 15, 2011 eligibility and January 2011 MMA return file (Analysis and Research run 2/9/2011).

[v] Source: Centers for Medicare and Medicaid Services, Special Needs Plan Comprehensive Report February 2011.

[vi] Source: Derived by subtracting SNP enrollment reported by CMS from Medicare managed care enrollment shown in DMAP DSSURS data warehouse, Jan 15, 2011 eligibility and January 2011 MMA return file (Analysis and Research run 2/9/2011)

[vii] Source: Centers for Medicare and Medicaid Services, Special Needs Plan Comprehensive Report February 2011

[viii]Source: List of dual eligible enrollment in Medicaid plans supplied by DMAP (July 2009).

[ix] Source: DHS December 2010 rebalance, rounded to nearest $10 million.

[x] Source: DHS December 2010 rebalance, rounded to nearest $10 million.

[xi] Sources: Total Medicare cost for Oregon dual eligible individuals estimated based on reported Medicare cost for all Oregon beneficiaries (CMS Office of the Actuary 2004), trended forward based on CMS historic and estimated rate of increase in national Medicare spend, and estimated share of Medicare spending for dual eligible individuals (MedPAC June 2010 Data Book).

[xii] Source: MedPAC June 2010 Data Book estimate of the share nursing home care consumes of Medicare cost for dual eligible enrollees.

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Health System Transformation Team

March 9, 2011

Summary of the work of the Health Policy Board's Medical Liability Task Force

Oregon Health Authority

The Health Policy Board created the Medical Liability Task Force

Its charge:

- Investigate the current medical liability system
- Suggest opportunities for reform
- Prioritize patient safety and reduction of medical errors
- Encourage better physician-patient communication
- Reduce frequency of frivolous lawsuits
- Ensure patients are compensated adequately

Framework for Task Force Deliberations

Task Force Goals for results of reform:

- The medical liability system becomes a more effective tool for improving patient safety
- The medical liability system more effectively compensates individuals who are injured as a result of medical error
- The collateral costs associated with the liability system are reduced (including costs of insurance administration, litigation, and defensive medicine)

The Collateral Costs Associated with the Liability System

Background facts:

- Cost of payments to Oregon patients - About $46 million (=0.24% of health care spending)
- Cost of malpractice insurance administration and defense of claims – About $34 million (=0.18% of health care spending)
- Cost of defensive medicine – National estimates range from 0.3% to more than 7% of health care spending
  - Definition: Defensive medicine is tests and procedures performed primarily to protect the provider against malpractice claims.

Issues Selected for Study

- Disclosure and offer programs
  - Concept: Health care providers and facilities disclose errors, investigate cause, and make early offer of payment when negligence is clear.
- Evidence-based guideline safe harbors
  - Concept: Physicians are expected to follow state-designated evidence-based guidelines; if they do, they cannot be found liable for malpractice.
- Health courts
  - Concept: Specialized courts or an administrative system replaces the tort system for compensating victims of negligence. New system would involve a trade-off: Tort system would be eliminated but more patients injured by errors would be compensated.

Concepts Not Selected for Development

- Many traditional tort reform concepts not selected because they would not advance the three key goals.
- Caps on damages
  - Caps limit amounts that can be awarded in a case
  - Evidence suggests caps may reduce premiums but they don't accomplish other goals
  - Caps cannot be imposed without amending Oregon's constitution (and voters have refused to do it)
- Excess liability fund
  - A state fund would pay verdicts in excess of insurance limits, relieving physicians of exposure
  - Fund is not realistic in current budget environment

Health Policy Board Actions

- Disclosure
  - SB 95 clarifies that malpractice insurer may not refuse to defend a case because the physician disclosed an adverse event to a patient
  - SB 95 extends the apology law to protect facilities as well as physicians
- Evidence-based guideline safe harbors
  - Planning grant continues through September 2011
- Health Courts
  - Looking into the cost of health court feasibility study

For more information

The final report of the Medical Liability Task Force is available at:

http://www.oregon.gov/OHPPR/HPB/MedicalLiability/Docs/FinalReport_Dec2010.pdf

Oregon Health Authority

Oregon Health Policy Board
Office for
Oregon Health Policy and Research

Oregon Medical Liability Task Force Report and Recommendations

Submitted to the Oregon Health Policy Board:
December 2010

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Medical Liability Task Force Membership

Co-Chairs:

J. Michael Alexander, JD
Swanson, Lathen, Alexander,
McCann & Prestwich, PC

Joseph Siemienczuk, MD
Chief Medical Officer
Providence Medical Group-North
Providence Health & Services

Members:

Rick Bennett
Government Relations
AARP

Peter Bernardo, MD
General Surgeon, Private Practice

Jeffrey Bildstein, JD
Vice President
Western Litigation, Inc

Janet Billups, JD
OHSU Legal Counsel

Jim Dameron
Executive Director
Oregon Patient Safety Commission

Craig Fausel, MD
Physician/President & CEO
The Oregon Clinic

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Members (cont.)

Robert Holland, MD
Physician & Medical Examiner
Grant County

Jodie Mooney, JD
Director of Risk Management &
Organizational Integrity
PeaceHealth Oregon Region

Laura Potter
District Executive Director
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Christoffer Poulsen, DO
Emergency Medicine Physician
Eugene Emergency Physicians
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Mark Stevenson
President and CEO
Capital Pacific Bank

Lawrence Wobbrock, JD
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Jeanene Smith, MD, MPH
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Executive Summary

The Medical Liability Task Force was appointed by the Oregon Health Policy Board in March 2010 to develop medical liability reform proposals for consideration by the Policy Board and the Legislature.

The Task Force identified three patient-centered goals for system improvement and agreed that successful medical liability reform should further those goals. They are:

1. The medical liability system becomes a more effective tool for improving patient safety;
2. The medical liability system more effectively compensates individuals who are injured as a result of medical errors; and
3. The collateral costs associated with the medical liability system (including costs associated with insurance administration, litigation, and defensive medicine) are reduced.

The Task Force prioritized three reform concepts for consideration because they seemed to hold some promise for helping achieve the goals for system improvement: Disclosure and offer programs, evidence-based guideline safe harbors, and health courts.

The Task Force chose not to look for ways to reduce indemnity payments (that is, payments to injured patients) primarily because non-economic damage caps—which have been imposed in some states to reduce indemnity payments--cannot be imposed in Oregon without a constitutional change that the state's voters have rejected twice. In addition, many members of the Task Force believe that the system should compensate more, not fewer, individuals harmed by medical errors.

The Task Force makes the following recommendations designed to spur providers and facilities to disclose medical errors to their patients and, where possible, to offer compensation to patients harmed by those errors:

- The legislature should enact a statute explicitly providing that a health care facility or provider's duty to cooperate with an insurer does not preclude disclosure of an adverse event or the reasons underlying it to a patient or the patient's family and that such disclosure may not be the grounds for refusal to defend or for cancellation or nonrenewal of coverage. This should remove insurance concerns as a barrier to full disclosure.
- The legislature should consider amending Oregon's "apology" law, which precludes use of statements made to a patient that express "regret or apology" for harm that occurred during treatment to prove liability in a negligence case so that the law clearly protects facilities in addition to physicians and more clearly describes what statements are included in its protection.

- The legislature should consider requiring professionals and facilities to disclose to patients adverse events occurring as a consequence of their treatment and to provide explanations for them.
- The Oregon Patient Safety Commission should work with health care facilities that participate in its voluntary error reporting program to experiment with disclosure protocols that specify what they should disclose to patients under the reporting program.
- The legislature should consider expanding Oregon's voluntary reporting program to permit physician practices to participate, recognizing that confidential reporting of medical errors serves a different although complementary purpose than disclosure of errors to patients.

The Task Force makes the following recommendation concerning the work that has been funded by a grant from the Agency for Healthcare Research and Quality to develop a "safe harbor" program that changes medical liability rules to encourage physicians to use evidence-based practice guidelines:

- To explore the potential value of using evidence-based guidelines as the legal standard of care, policymakers should support the completion of the grant activity.
- As the grant moves forward, a broadly representative set of individuals should be included in the planning process.

The Task Force considered proposals to replace the existing medical liability system with a new system for compensating patients harmed by medical treatment, even if their care was not negligent. It is assumed that such a program would compensate more individuals than the current system and would involve an administrative rather than a court-based system for adjudicating claims. The Task Force reached this conclusion:

- It would be worthwhile for the Legislature or the Oregon Health Authority to sponsor a study to determine whether or not an administrative system could be designed that would achieve the reform objectives the Task Force has enunciated and if so, whether implementation is financially, legally, and politically feasible. The study should be overseen by an unbiased entity that has not taken a position for or against the health courts concept. It should be conducted by a well-qualified team with knowledge of the existing medical liability system, knowledge of administrative compensation systems in the United States and elsewhere, skill in economic and social research and modeling, legal and actuarial expertise, and funding sufficient to do a thorough job.

The Task Force appreciates the opportunity to study these issues and encourages the board to continue this work.

I. Charge to the Task Force

The Medical Liability Task Force was appointed by the Oregon Health Policy Board in March 2010 to develop medical liability reform proposals for consideration by the Policy Board and the Legislature.

The Board instructed the Task Force to be guided by the Triple Aim, seeking to improve population health by "improving access to care;" improve access to and experience of care by "assuring healthcare providers do not cease to provide specific services in response to liability concerns;" and reduce per capita costs by "reducing the costs associated with defensive medicine."

The charter read:

> "The Medical Liability Task Force will investigate the current medical liability system and suggest opportunities for reform in Oregon including, but not limited to, caps on non-economic damage awards, disclosure-and-offer programs, shifting the adjudication of medical malpractice claims to administrative panels or specialized judicial courts, and the creation of "safe harbors" where physicians are insulated from liability if they adhere to evidence-based practices or practice according to findings from credible comparative-effectiveness research (CER).
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> * * *
>
> "Recommendations should prioritize patient safety and the reduction of medical errors, encourage better communication between physicians and patients, reduce the occurrence of frivolous lawsuits, and reduce liability premiums, while also ensuring that patients are compensated in an equitable and timely way for medical injuries."

II. Framework for Deliberations

The Task Force chose to focus its attention on finding ways to further three goals for system improvement. The goals were identified with the Policy Board's patient-centric focus in mind. Successful reform will mean

1. The medical liability system becomes a more effective tool for improving patient safety;
2. The medical liability system more effectively compensates individuals who are injured as a result of medical errors; and
3. The collateral costs associated with the medical liability system (including costs associated with insurance administration, litigation, and defensive medicine) are reduced.

The Task Force identified five questions that should be asked about any proposal to change the medical liability system. They are:

1. What is the likely effect of the proposal on patient safety?
2. What is the likely effect of the proposal on access to compensation for patient injury?
3. What is the likely effect of the proposal on health care costs?
4. Is the proposal feasible?
5. Can the proposal be implemented without statutory or constitutional changes? If not, what changes are necessary?

III. Background

The Task Force would have preferred to begin its work with a complete understanding of the problem of medical errors in Oregon, the performance and costs of the medical liability system in Oregon, and the collateral costs of the medical liability system, including costs of administration, litigation, and defensive medicine.

Unfortunately, the Task Force found that information is not available to support a thorough understanding of the systems we have today—which may be one reason there is no consensus around proposals for change. Oregon does not track medical errors in a comprehensive way. The Oregon Medical Board tracks payments in claims against physicians, but the state does not track payments in claims against institutions or other licensed professionals. Oregon knows something about the cost to physicians of the liability system because medical liability insurers licensed in Oregon must file premium rates and total premium written; but increasing numbers of physicians are employed by self-insured health care institutions. This confounds efforts to trend cost or generate aggregate cost figures.

The Task Force proceeded with its work based on the personal knowledge of participants, national estimates of errors and liability system costs, and preliminary information supplied by staff from public and insurer sources. We offer the following paragraphs to help inform our readers.

A. Patient Safety

The seminal authority on the issue of medical errors remains the 1999 Institute of Medicine's landmark report entitled "To Err Is Human". Relying on the Harvard Medical

Practice Study's review of a random sample of 1984 hospital records in New York State,[1] the IOM estimated that as many as 98,000 individuals die every year from preventable medical errors in American hospitals.[2] The Harvard Medical Practice Study count included patients who died in hospitals due to diagnostic and other errors that occurred on an outpatient basis.

The Harvard research team estimated the national economic burden of 1984 medical errors at $50 billion in 1989 dollars. About half the cost was for additional health services; about half for lost earnings and household productivity.[3] A similar study was done using 1992 hospital records from Colorado and Utah. An article describing the study estimated the national burden of 1992 medical errors in 1996 dollars at $37.6 billion for all adverse events and $17 billion for preventable ones. Again, about half of the costs were for additional health services and half for lost earnings and productivity.[4]

No study comparable to the New York or Colorado/Utah studies has been done to measure the frequency or cost of medical errors in Oregon. The Oregon Patient Safety Commission (OPSC) operates medical error reporting programs. While the programs provide important information to support facility improvement programs, they cannot yet generate a comprehensive picture of the medical errors that occur. Hospitals, nursing homes, ambulatory surgery centers, and pharmacies may participate in the OPSC programs, but physician practices may not. In 2009, the Patient Safety Commission received reports of 32 medical errors resulting in patient death.[5] Relying on data from Pennsylvania, where a mandatory hospital error reporting system has been in place since 2004, Oregon's Public Health Officer estimated that 1600 serious adverse events resulting in patient harm occurred in 2008 in Oregon hospitals alone.[6] Many of these injuries can and should be prevented.

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[1] Brennan, T.A., Leape, L.L., Laird, N.M., Hebert, L., Localio, A.R., Lawthers, A.G., Newhouse, J.P., Weiler, P.C., & Hiatt, H.H. (1991, February 7). Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. *New England Journal of Medicine*, 324(6):370-6.

[2] Kohn, L.T., Corrigan, J.M., & Donaldson, M.S. (1999). *To Err Is Human: Building a Safer Health System*. Institute of Medicine. Washington, DC: National Academy Press.

[3] Johnson, W.G., Brennan, T.A., Newhouse, J.P., Leape, L.L., Lawthers, A.G., Hiatt, H.H., & Weiler, P.C. (1992, May 13). The Economic Consequences of Medical Injuries. *The Journal of the American Medical Association*. 267(18):2487–2492.

[4] Thomas, E.J., Studdert, D.M., Newhouse, J.P., Zbar, B.I.W., Howard, K.M., Williams, E.J., & Brennan, T.A. (1999, Fall). Costs of Medical Injuries in Utah and Colorado. *Inquiry*.

[5] In 2009, Oregon hospitals reported 127 serious adverse events, 32 of which resulted in death. Oregon Patient Safety Commission. (2010, August). Hospital Report. Available: http://oregon.gov/OPSC/docs/Reports/Hospital-Report-081910.pdf [2010, October 14]

[6] Oregon Department of Human Services, Public Health Division. (2009, August). Public Health Officer Certification Report 2008 – Oregon Patient Safety Commission Adverse Event Reporting Programs. Available: http://oregon.gov/PHOCertificationReport2008_Final_1.pdf [2010, October 14]

B. Access to Compensation

Our current tort system's principal purpose is to provide compensation to victims of negligence. As it applies to medical claims, it is a fault-based system, meaning that compensation may be awarded only if the medical provider is shown to have rendered unreasonable care. Because there is no comprehensive data on the numbers of *negligent* medical errors occurring in Oregon each year, it is impossible to calculate the degree to which the tort system accomplishes its goal.

There is no question, however, that many people who are harmed by medical negligence do not receive compensation through the tort system. Several studies using data from other states have been conducted. For each, physicians examined hospital records to identify adverse events caused by medical negligence. Researchers then map the events against records of malpractice claims. The studies have found that 97.5-98% of patients injured by medical negligence did not file claims.[7]

This suggests that the system as it now functions is a less-than-perfect vehicle for compensating victims of medical negligence and probably an even less satisfactory vehicle for compensation victims of preventable medical errors—that is, errors that could have been prevented had best practices been followed. The reasons why so few are compensated, however, is an issue requiring further study.

C. Collateral Costs

1. Total system costs

The costs of the medical liability system (as opposed to economic burden of the treatment-related injuries themselves) include both compensation paid for injury and the system's collateral costs—primarily the costs of insurance administration and litigation and costs associated with diagnostic and treatment activities undertaken primarily to avoid malpractice liability or claims (that is, "defensive medicine").

At least three estimates of the national cost of the medical liability system have been published recently. The estimates of "direct cost" range from .43% to 2% of national health care spending. Public Citizen, relying on estimates of malpractice premiums alone, estimated direct costs at 0.46% of health care spending.[8] Michelle Mello and colleagues at the Harvard School of Public Health estimated total direct costs (that is, indemnity

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[7] Localio, A.R., Lawthers, A.G., Brennan, T.A., Laird, N.M., Hebert, L.E., Peterson, L.M., Newhouse, J.P., Weiler, P.C., & Hiatt, H.H. (1991, July 25). Relation Between Malpractice Claims and Adverse Events Due to Negligence. *New England Journal of Medicine*. 325(4):245-251. Studdert, D.M., Thomas, E.J., Burstin, H.R., Zbar, B.I.W., Orav, E.J., & Brennan, T.A. (2000, March). Negligent Care and Malpractice Claiming Behavior in Utah and Colorado. *Medical Care*. 38(3):250-60.

[8] Public Citizen. (2010, March 3). Medical Malpractice Payments Fall Again in 2009. Available: www.citizen.org/documents/NPDBFinal.pdf [2010, October 14]

payments plus administrative costs) at $9.85 billion in 2008—or 0.43% of total health care spending. Their estimate was based on data on payments, studies of defense costs, and studies of insurance overhead costs—all cited in a paper published in Health Affairs.[9] The Congressional Budget Office offered a much larger estimate of direct cost in a letter concerning the potential savings from specific tort reform proposals. The method CBO used to generate its estimate of $35 billion—or about 2% of health care spending—is not explained in detail.[10]

Mello and colleagues sought to estimate the indirect as well as the direct costs of the medical liability system. To do that, they added estimates of lost physician productivity and defensive medicine to their estimates for direct costs. They pegged total cost at $55.6 billion a year—with almost 80% of it resulting from defensive medicine. If their estimate is correct, the direct and indirect costs of the liability system are 2.4% of total health care spending.

The problem with all of these estimates is that they include both compensation and collateral cost; so while they are a good measure of the burden of the system on health care practitioners, they are not particularly useful in identifying the collateral costs that the Task Force seeks to reduce. Therefore, we turn to studies that seek to parse these costs.

2. Cost of indemnity payments

Mello et al estimated the total national cost of indemnity payments—that is payments to compensate for the economic and noneconomic consequences of patient injuries -- at $5.7 billion a year or 0.25% of national health care spending. The calculation started with the total indemnity payments reported to the National Practitioner Data Bank and a multiplier developed from the literature and insurer records to account for indemnity payments on behalf of institutions (which are not reported to the data bank).

Using Mello's methodology and National Practitioner Data Bank figures for Oregon, the Office for Oregon Health Policy & Research estimates that indemnity payments paid in claims against professionals and facilities in Oregon totaled about $46.4 million in 2008 -- that is, 0.24% of estimated Oregon health care spending.[11]

Total indemnity payments made for incidents involving claims against Oregon physicians appears to have trended upward over the last decade according to data reported to the Oregon Medical Board. Whether this truly reflects a growing cost burden, however, would require adjusting these payments for inflation and for growth in population or in volume of

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[9] Mello, M.M., Chandra, A., Gawande, A.A., & Studdert, D.M. (2010, September.) National Costs of the Medical Liability System. *Health Affairs.* 29(9):1569-77.

[10] Congressional Budget Office. (2009, October 9). Letter to Honorable Orrin G. Hatch. Available: www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf [2010, October 14]

[11] The Office for Oregon Health Policy and Research has estimated total health care spending for 2008 at $19.3 billion.

health services provided—an exercise the Task Force did not undertake. For more detail on trends in claim frequency and indemnity payments, see Appendix 1.

3. Costs of insurance administration and litigation

Mello et al estimated the total national cost of insurance administration and defendant legal expenses at $4.13 billion in 2008—with an additional $2.0 billion in legal costs borne by injured patients out of their recoveries.[12]

If the relationship between indemnity cost and administration and litigation costs in the Mello estimates holds true for Oregon, malpractice insurance administration and defense litigation costs would have consumed about $33.6 million in Oregon in 2008.

4. Costs of defensive medicine

Increased health care costs associated with defensive medicine are notoriously difficult to measure. Estimates of share of health care spending attributable to defensive medicine range from about 0.3% to more than 7%.

Defensive medicine results in performance of tests and procedures primarily to avoid malpractice liability. Measuring it requires assessing why physicians make the diagnostic and treatment decisions they make. It would be difficult enough to determine in any particular case whether a decision to order a particular diagnostic imaging study was made primarily because the physician believed it to be necessary for the patient's care or primarily to ensure that his diagnosis would not be questioned in a malpractice suit. The analysis is yet more difficult because good patient care and fear of malpractice suits are not the only factors affecting physician decision-making. For example, fee-for-service payment incentives can reinforce medical malpractice incentives to order unnecessary services. Because of the difficulty of measuring the extent of defensive medicine, members of the Task Force agreed not to attempt to agree on its prevalence. Nevertheless, because defensive medicine is a large component of most estimates of total medical liability cost, we address it briefly here.

In a 2006 paper published by the Robert Wood Johnson Foundation, Michelle Mello, wrote:

> "There are no reliable estimates of the national costs of defensive medicine. Many analysts have attempted to estimate these costs; all have failed to do so reliably. All of the available measurement methodologies have serious shortcomings (10, 18). For example, some national estimates are based on the incremental cost increases associated with just two or three medical procedures or diagnoses. It is simply not possible to extrapolate so widely to other procedures, because some are more amenable to defensive medical practice than others. The Office of Technology

[12] See footnote 9.

> Assessment conducted a comprehensive review of the evidence about defensive medicine costs in 1994 and concluded that none of available estimates were reliable (32). Much additional research has been conducted since then, but the conclusion remains the same."[13]

Nevertheless, a number of attempts have been made to quantify the defensive medicine phenomenon. We mention several below.

One of the larger estimates is described by the Stuart L. Weinstein, past president of the American Society of Orthopedists, in a posting on the society's website. He writes:

> "The study quoted most often is by Daniel P. Kessler and Mark B. McClellan. To really understand actual costs, Kessler and McClellan analyzed the effects of malpractice liability reforms using data on Medicare beneficiaries who were treated for serious heart disease. They found that liability reforms could reduce defensive medicine practices, leading to a 5 percent to 9 percent reduction in medical expenditures without any effect on mortality or medical complications.
>
> "If the Kessler and McClellan estimates were applied to total U.S. healthcare spending in 2005, the defensive medicine costs would total between $100 billion and $178 billion per year."[14]

Most experts would concede that Weinstein's is a high estimate, built on an assumption that findings of Kessler and McClellan with respect to a small class of cases can be extrapolated to the system as a whole.

More conservative estimates have been authored by the Congressional Budget Office and J. William Thomas and colleagues at the Cutler Institute for Health and Social Policy. The Congressional Budget Office, based on a review of published research, estimated that enactment of a package of traditional tort reforms—including caps on damages—would reduce total health spending by 0.3%.[15] Thomas et al, based on an extensive analysis of health insurance claims data, predicted that while reductions in medical liability premiums would result in a significant reduction in costs for 2% of conditions, "across all thirty-five specialties [studied], savings associated with a 10% percent reduction in medical malpractice premiums would be just 0.132 percent."[16]

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[13] Mello, M.M. (2006, January). Understanding Malpractice Insurance: A Primer. Robert Wood Johnson Foundation. Available: www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_primer.pdf [2010, October 14]

[14] Weinstein, S.L., The Cost of Defensive Medicine. Available: http://www.aaos.org/news/aaosnow/nov08/managing7.asp [October 21, 2010]

[15] See footnote 10.

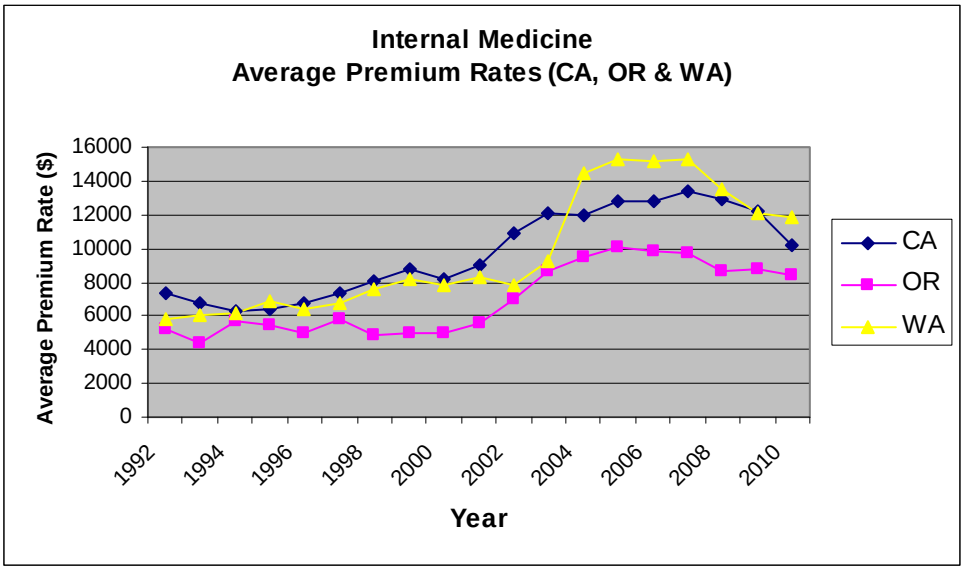
[16] Thomas, J.W., Ziller, E.C., and Thayer, D.A. (2010, September). Low Costs of Defensive Medicine, Small Savings From Tort Reform. *Health Affairs* 29(9):1578-1584.

As part of their 2010 study of the costs of the medical liability system, Mello and colleagues also attempted to estimate the cost of defensive medicine. Relying on the Kessler study and others, they pegged annual defensive medicine costs for hospitals and physicians at $45.49 billion—or about 1.97% of total health care costs. They warned, however, that "Although our figure was based on methodologically strong studies, because the hospital spending estimates were derived from a narrow range of diagnoses, the quality of evidence supporting our system-wide estimate is best characterized as low."[17]

D. Medical Liability Premiums in Oregon

Medical liability premium levels are set by insurers. Rates differ greatly by provider specialty. We examined premium trend and Oregon premiums compared with premiums in neighboring states.

The Medical Liability Monitor reports premium rates for major carriers by state for three specialties—internal medicine, obstetrics and gynecology, and general surgery. Comparing average rates for these specialties in Oregon, Washington, and California shows premiums have been lower in Oregon than in neighboring states for every year of the last two decades with the exception of three years, when average Oregon rates for obstetrics and gynecology exceeded California rates, and one year, when average Oregon rates for general surgery were the same as California's. To illustrate, see the chart below. For additional charts and an explanation of the Monitor's reporting, see Appendix 2.



Although Oregon medical liability premium rates are low relative to rates in neighboring states, premium rates tend to be volatile, reflecting what is known as the insurance cycle. This volatility makes it difficult for physicians to predict their costs. During "soft" phases of

[17] See footnote 9.

the cycle, insurers keep premiums low in an effort to build market share. During "hard" phases of the cycle, premiums rise as insurers protect their profitability, often during periods where investment returns are low.[18] Oregon is currently in the soft phase of the cycle. Some national commentators are predicting increases in claims frequency and costs, however, which could presage a return to the hard phase of the cycle.

According to the Department of Consumer and Business Services, Oregon's insurance regulator, Oregon's two dominant medical liability carriers, representing 57% of the professional liability market in Oregon, have dropped their premiums an average of 20% over the past five years.[19] The chart below is taken from a DCBS press release:

Medical Liability Premium Rate Trends in Oregon

Year	NPIC/Doctors Company*	CNA
2006	-8.3%	+1.9%
2007	-10.2%	-3.2%
2008	-8.9%	-7.6%
2009	0%	-2.5%
2010	-5.1%	0%

During the last hard phase of the cycle, Oregon physicians delivering babies in rural Oregon reported soaring premiums. The legislature responded by creating a malpractice premium subsidy program for rural physicians in 2003. The program is scheduled to expire in 2011. For more detail about the program, see Appendix 3.

IV. Reform Concepts Selected for Consideration

The Task Force prioritized three reform concepts for consideration. They were disclosure and offer programs; evidence-based guideline safe harbors; and health courts. These concepts are discussed in detail below.

The Task Force chose not to look for ways to reduce indemnity payments (that is, payments to injured patients) for at least three reasons: First and most importantly, non-economic damage caps—although favored by some groups nationally--cannot be imposed in Oregon without a constitutional change that the state's voters have rejected twice. Therefore, all members of the Task Force agreed that pursuing a caps strategy would not be fruitful. Second, while some Task Force members are more comfortable than others with who gets compensated and how much in today's liability environment, most members of the group

[18] Mello, M.M. (2006, January). Understanding Malpractice Insurance: A Primer. Robert Wood Johnson Foundation. Available: www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_primer.pdf [2010, October 14]

[19] Oregon Department of Consumer & Business Services (2010, April 15). Press release: Oregon medical malpractice rates continue to decrease. Available: http://egov.oregon.gov/DCBS/docs/news_releases/2010/nr_ins_04_15_10.pdf [2010, October 14]

do not believe the total amount of money spent to compensate victims of medical negligence is excessive. Most believe that more people should be compensated. Third, some physician members of the Task Force noted that while the volatility of medical liability premiums is troublesome for health care professionals, most have been able to manage the current premium levels. According to the Department of Consumer and Business Services, most physicians and surgeons in Oregon have seen declines or no change in medical professional liability insurance rates for the last four years.[20]

The Task Force also chose not to address the imminent expiration of Oregon's premium subsidy program for rural physicians. The issue is being studied by a legislative committee. Rather than attempting to weigh in on a subject the Task Force has not thoroughly studied, the Task Force chose to defer to that committee.

The following sections of the report summarize the Task Force's recommendations, the thinking behind them, and differences of opinion among members of the Task Force. Recommendations are shown in boldface type.

V. Recommendations to Support and Encourage "Disclosure and Offer" Programs

A. Discussion of Disclosure and "Disclosure and Offer Programs"

Health care providers are trained to tell patients about unanticipated outcomes that occur in the course of their medical care. That means they should explain events that cause their patients harm—including the treating professionals' understanding about the cause of the event: Was it occasioned by progression of the underlying disease process or by the treatment itself? If by medical treatment, was it an anticipated risk of treatment—that is, something that is expected to happen in some but not all cases? Or was it a result of a defect in the care that was provided? Could it have been prevented?

Nevertheless, historically, medical culture coupled with provider fear of medical liability lawsuits has meant that most providers have been reluctant to discuss these issues openly with patients. This culture of nondisclosure has been reinforced by liability insurers, some of whose personnel instruct providers they insure not to discuss adverse events with patients or others.

There is increasing interest, however, in fostering disclosure because it is consistent with a transparent, patient-centered approach to health care. Disclosure is useful whether or not it is required. It facilitates patient participation in decision-making about their care and enables informed consent. In addition, organizations with a culture that fosters discussion of mishaps are better positioned to explore the causes of patient injuries and prevent avoidable recurrences.

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[20] *Ibid.*

Disclosure may be a good business practice as well: Research suggests that disclosure of errors to patients may reduce rather than increase the incidence of lawsuits; and, when disclosure is coupled with early offers of compensation, it may reduce litigation costs and the size of indemnity payments. An article published in the September issue of *Annals of Internal Medicine* examined the experience of the University of Michigan Health Systems, finding that the number of claims resulting in lawsuits, the cost of compensation, and total program costs declined significantly after adoption of a disclosure and offer program.[21]

Finally, disclosure of some adverse events is required by agencies like the Joint Commission, which accredits hospitals, and the Oregon Patient Safety Commission, which operates a voluntary error reporting program for health care facilities.[22]

The Task Force concludes that providers and facilities should be encouraged to disclose adverse treatment events and discuss them openly with patients. They should further be encouraged to offer fair compensation as soon as possible to patients who have clearly been injured due to medical negligence. When patients are asked to give up their right to sue in exchange for an offer of compensation, providers should encourage patients to consult a lawyer to assist them in negotiating a fair agreement. This "disclosure *and* offer" approach has been adopted by some self-insured hospitals and integrated health systems in Oregon. Providers and facilities that do not self-insure, however, will need the cooperation of their insurers to adopt this approach.

State policymakers should remove obstacles to disclosure and consider requiring it in some circumstances. The choice to make early offers of compensation will necessarily remain with individual self-insured entities and insurers.

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[21] Kachalia, A., Kaufman, S.R., Boothman, R., Anderson, S., Welch, K., Saint, S., & Rogers, M.A.M. (2010, August 17). Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program. *Annals of Internal Medicine*. 153(4):213-221. Kraman, S.S., & Hamm, G. (1999, December 21). Risk Management: Extreme Honesty May Be the Best Policy. *Annals of Internal Medicine*. 131(12):963-967.

[22] Joint Commission accrediting standards provide that hospitals must inform patients of "unanticipated outcomes of care, treatment, and services that relate to sentinel events considered reviewable by the Commission." Licensed practitioners responsible for managing a patient's care (or their designee) must inform "the patient about unanticipated outcomes of care, treatment, and services related to sentinel events when the patient is not already aware of the occurrence or when further discussion is needed." Joint Commission Standard: RI.01.02.01-21. Oregon statute provides that "After a serious adverse event occurs, a participant [in the Patient Safety Commission's reporting program] must provide written notification in a timely manner to each patient served by the participant who is affected by the event. Notice provided under this subsection may not be construed as an admission of liability in a civil action." ORS 442.837(4).

B. Specific Recommendations to Remove Barriers to Disclosure

The Task Force considered three policy concepts for increasing disclosure to patients and thereby facilitating early resolution of malpractice claims. Each would build on the "apology" law enacted in 2003. That law provides that expressions of regret or apology made by physicians or others on their behalf cannot be used to establish liability in a negligence lawsuit against a physician.[23]

The apology statute, while useful, has proved insufficient to eliminate liability system barriers to disclosure. Some physicians report that malpractice insurers continue to instruct physicians not to discuss events that could lead to lawsuits. These physicians fear that if they disclose errors they will be guilty of "noncooperation" and their insurers may be entitled to refuse to defend them in court.

To remove insurance concerns as a barrier to full disclosure, the legislature should enact a statute explicitly providing that a health care facility or provider's duty to cooperate with an insurer does not preclude disclosure of an adverse event or the reasons underlying it to a patient or the patient's family and that such disclosure may not be the grounds for refusal to defend or for cancellation or nonrenewal of coverage. (For language that could be used, see Appendix 4.)

The legislature should also consider amending the "apology" law to expressly protect facilities as well as physicians and to more clearly describe what statements made to a patient are inadmissible expressions of "regret or apology".[24]

The Task Force believes the legislature should also consider requiring professionals and facilities to disclose to patients adverse events occurring as a consequence of their treatment and to provide explanations for them.[25] If a mandatory disclosure law were

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[23] The law reads:

> ORS 677.082 (1) For the purposes of any civil action against a person licensed by the Oregon Medical Board, any expression of regret or apology made by or on behalf of the person, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability for any purpose.
>
> (2) A person who is licensed by the Oregon Medical Board, or any other person who makes an expression of regret or apology on behalf of a person who is licensed by the Oregon Medical Board, may not be examined by deposition or otherwise in any civil or administrative proceeding, including any arbitration or mediation proceeding, with respect to an expression of regret or apology made by or on behalf of the person, including expressions of regret or apology that are made in writing, orally or by conduct.

[24] The general concept of offering broad protection appears in Mastroianni, A.C., Mello, M.M, Sommer, S., Hardy, M., & Gallagher, T.H. (2010, September). The Flaws in State 'Apology' and 'Disclosure' Laws Dilute Their Intended Impact on Malpractice Suits. *Health Affairs*. 29(9):1611-1619.

[25] One member expressed the view, however, that mandatory disclosure should not be considered because the voluntary reporting and disclosure law is working well now.

enacted, Oregon would join seven other states—among them California, Florida, Nevada, New Jersey, Pennsylvania, and Vermont.[26]

At present, Oregon facilities that choose to participate in the Oregon Patient Safety Commission's error reporting program are required to disclose reportable adverse events to the patient. ORS 442.837(4). Neither health care facilities declining to participate in the commission's voluntary program nor individual health care professionals have any legal obligation to make any disclosure. Moreover, the commission has not spelled out what is to be included in the disclosure.

Finally, the Task Force recommends that the Oregon Patient Safety Commission work with health care facilities to experiment with disclosure protocols that specify the elements of the required disclosure to patients.

C. Recommendations Relating to Reporting Laws

Members of the Task Force debated the value of strengthening Oregon's reporting programs as a strategy for encouraging disclosure.

Oregon law permits but does not require hospitals, ambulatory surgery centers, long term care facilities, outpatient renal dialysis facilities, free-standing birthing centers, and pharmacies to participate in the Patient Safety Commission's reporting program. Physician practices—regardless of size—may not participate in the program.[27]

Most states now require health care facilities to report medical errors to a patient safety organization which uses the data to measure the prevalence and type of errors and develop prevention strategies. Most states make the reports confidential to encourage candor. Some reporting programs, like Oregon's voluntary program, require the error to be disclosed to the patient while protecting the reports themselves from disclosure to either the patient or the public.

Expanding participation in Oregon's reporting program might result in increased disclosure because the reporting program includes a requirement that facilities notify patients in writing when a serious adverse event occurs. Nevertheless, a disclosure requirement could be enacted independent of the reporting program. Therefore, the Task Force discussed whether an expanded reporting program would have any value as a tool to encourage disclosure apart from the program's notice requirement.

The values and objectives supported by reporting, disclosure, and disclosure and offer programs are summarized in the table below. (An "x" suggests the program will further the value or objective listed in the left column. The table does not reflect variation in the

[26] For a summary of disclosure laws, see Appendix 5.
[27] ORS 442.837.

degree to which a program furthers a particular objective. For example, while disclosure by itself may reduce litigation cost, savings are presumably greater if an offer and settlement occur as well.)

	Reporting	Disclosure	Disclosure/offer
Patient right to know		X	X
Improved access to compensation		X	X
Reduced litigation cost		X	X
Support for culture of safety	X	X	X
Support for cross-institutional prevention efforts	X		

Some members of the Task Force believe that reporting requirements have supported development of a culture of openness about medical errors that fosters development of disclosure programs in participating institutions. Some of them are open to the possibility that mandatory reporting laws would increase the practice of disclosure that the Task Force supports.

Others members are reluctant to view reporting laws as tools for encouraging disclosure. Many of them oppose expansion of reporting requirements either by making reporting mandatory or opening the existing voluntary program to participation by additional providers.

The Task Force recommends that the legislature consider expanding Oregon's voluntary reporting program to permit physician practices to participate, recognizing that this would involve developing approaches to reporting that fit this new site of care and dealing with a large number of separate entities. It would also be a major workload increase for the Commission. Two members expressed reservations, although for differing reasons.[28]

D. Other measures to encourage disclosure

Some nationally recognized advocates for early disclosure and offer programs have suggested that states offer state-funded financial incentives to facilities adopting the programs. Some suggest creating state reinsurance or excess liability funds for providers

[24] Several members of the task force believe that changes in the reporting law should not be considered. One believes a change would be unwise, the other that it is beyond the scope of the task force's charge.

and facilities that implement model early disclosure and offer programs.[29] Such a fund would be designed to protect facilities from the risk that disclosing more errors would increase their medical liability costs. The Task Force does not recommend pursuing this option, primarily because creating a new source of payment for claims would not seem to further the priority objectives adopted as a framework for the Task Force's work. In addition, the evidence to date suggests that disclosure and offer programs may make business sense and expenditure of public dollars may not be needed to encourage them.

VI. Evidence-Based Guideline Safe Harbor Approach

Oregon health care leaders and policy makers have a long history of commitment to evidence-based approaches to health care policy making. This has included use of evidence-based practice guidelines to improve the quality of care and reduce costs in the health care delivery system. The legislature has instructed the Health Resources Commission, Oregon's medical technology assessment entity, to develop evidence-based guidelines for use by providers, consumers, and purchasers in Oregon and directed the health authority to use the guidelines in purchasing for care in all of the programs it manages. We believe that increased use of evidence-based clinical practice guidelines and process standards by providers may improve quality and reduce medical errors.

Oregon has been awarded an Agency for Healthcare Research and Quality planning grant to explore evidence-based guidelines as a safe harbor. The grant supports development of a proposal for a specific medical liability reform that is designed to improve patient safety. Over the course of the next year, the Office for Oregon Health Policy and Research – with assistance from the Patient Safety Commission and the Center for Evidence-based Policy at Oregon Health & Sciences University – will lead the planning process.

The purpose of the planning grant is to craft a broadly supported legislative proposal that will encourage use of guidelines by offering a safe harbor from medical liability when they act in reliance on state-endorsed evidence-based guidelines. The project will explore a method for adopting guidelines to address the clinical situations that result in significant numbers of patient injuries or medical liability claims. The project will also explore linking the legal standard of care to compliance with the guidelines to:

- provide physicians with greater clarity about the standard of care expected of them and assure them that, if they adhere to the guidelines, they will not be found liable for harm resulting from failure to do something that is inconsistent with the guidelines,
- give patients greater protection from substandard care, and

[29] Winter, A. (2010, April 1). The Medical Malpractice System: A Review of the Evidence. Presentation to the Medicare Payment Advisory Commission. Available: http://www.medpac.gov/transcripts/medical%20malpractice%20April%202010_public.pdf [2010, October 14]. Conversation between the Medical Liability Task Force and Allen Kachalia, MD, Harvard School of Public Health (2010, September 8).

- reduce the frequency of medical liability claims.

To explore the potential value of using evidence-based guidelines as the legal standard of care, the Task Force recommends that policymakers support the completion of the grant activity.

As the grant project moves forward, the Task Force recommends that a broadly representative set of individuals be included in the planning process.

The Task Force has raised some specific questions it expects the grant team to address:

- Are there collections of similar adverse events that could be prevented if a single evidence-based guideline was consistently followed? Have those adverse events historically resulted in significant malpractice cost?
- Would treating a guideline as the standard of care be likely to increase compliance with the guideline? Reduce adverse events? Reduce litigation cost?
- How and by whom should guidelines be selected for special status in the medical liability system? Based on what criteria?
- Although guidelines could not apply to all situations or supplant the traditional standard of care in all instances, could such guidelines establish the standard of care in specific situations? If so, would compliance with such standards insulate a physician from liability or merely be evidence of a lack of negligence? Conversely, would deviation from the guideline establish liability or merely be evidence of negligence?
- Would guidelines used for safe harbors need to be protocols in order to play the role of safe harbor in the legal system?
- How can it be assured that the guidelines will remain up to date and not hold up desirable innovation?

VII. An Administrative System for Compensating Patient Injuries

A. Background

In Oregon and around the country, critics of the medical liability system are proposing to replace the tort system for compensating victims of medical negligence and the medical liability insurance system with what some call "health courts." Most "health courts" proposals would create an administrative system for compensating injuries to patients from some or all unanticipated adverse outcomes of medical care—not just medical negligence. The Task Force studied the arguments offered by both proponents and opponents of health courts proposals.

The Task Force rejected the concept of creating a new court system but believes there may be value in developing an administrative system for compensating patient injuries. Some believe that the changes in our nation's health care insurance system occasioned by passage of the Patient Protection and Accountable Care Act can be leveraged to improve the liability system and reduce costs.

Proponents of health courts believe implementing an administrative system is likely to significantly improve the collection of data on unanticipated adverse outcomes thereby supporting safety improvement programs; foster development of consensus around best practices for avoiding patient injury; increase the number of individuals compensated by lowering the bar for recovery to something less than negligence; reduce the legal costs incurred by patients to establish their claims; result in speedier resolution of claims; produce more consistent decisions and awards; reduce administrative costs, including defense costs; and reduce overutilization of medical procedures driven by the practice of defensive medicine.[30]

Commentators critical of health courts share the proponents' desire to improve patient safety programs, improve access to compensation for victims of medical errors, and reduce collateral costs, including insurance-related costs and the costs of defensive medicine; but they doubt that an administrative compensation system will result in the hoped-for improvements. They believe that estimates of defensive medicine are greatly exaggerated. They point out that both deeply rooted medical culture and powerful fee-for-service payment incentives drive overutilization of medical procedures, confounding efforts to measure the effect of fear of lawsuits on utilization. In addition, they are concerned that administrative decision-makers may display pro-physician bias and that benefits available in an administrative system may be inadequate.[31]

Task Force members, for the most part, are neither proponents nor opponents of replacing the tort system with an administrative compensation system. They are persuaded, however, that the magnitude of the benefits envisioned by advocates for replacing the existing system are great and warrant giving the concept a hard look. They also believe that the anticipated benefits are not certain to materialize. The design issues are many and complex and the potential pitfalls are serious.

The value of replacing the existing liability system is probably not something that can be tested through pilot projects because it involves establishing a new and elaborate decision-making infrastructure and identifying new sources of revenue to fund the program.

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[30] Mello, M.M., & Kachalia, A. (2010, April). Evaluation of Options for Medical Malpractice System Reform. Medpac. Available: www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf [2010, October 14]. Common Good. (2006). Windows of Opportunity. Available: http://commongood.org/assets/attachments/Windows_of_opportunity_web.pdf [2010, October 14]

[31] Peters Jr., P.G. Health Courts? *Boston University Law Review* 88:227-286 (2008) Available: http://www.concurringopinions.com/archives/author/Boston-University-Law-Review [2010, October 27]

Additionally, experience with Florida's birth injury compensation system suggests that, in a voluntary system, those who cannot establish fault will elect an administrative remedy. However, those who have suffered injuries they believe may stem from negligence may elect the tort remedy, thereby undermining the financial sustainability of the program. Finally, many members of the Task Force believe that the changes in physician culture necessary to support great increases in error disclosure and reduction in defensive medicine are unlikely to occur in a voluntary system. Unless further study suggests that a pilot program would be workable and productive, it appears that replacing the medical liability system with an administrative system to compensate patient injuries will work only if it applies to all patients statewide.

B. Recommendation

The Task Force, with one member in dissent, concludes that it would be worthwhile for the Legislature or the Oregon Health Authority to sponsor a study to determine whether or not an administrative system could be designed that would achieve the reform objectives the Task Force has enunciated and if so, whether implementation is financially, legally, and politically feasible. [32]

The study should be overseen by an unbiased entity that has not taken a position for or against the health courts concept. It should be conducted by a well-qualified team with knowledge of the existing medical liability system, knowledge of administrative compensation systems in the United States and elsewhere, skill in economic and social research and modeling, legal and actuarial expertise, and funding sufficient to do a thorough job.

C. Scope of the recommended study

The primary component of the study should assume that an administrative compensation system would include the following basic features and be implemented statewide:

- Compensable events would embrace a defined class of patient injuries broader than the class of injuries caused by medical negligence. While it may be unlikely that a pure "no-fault" system is economically feasible, a "low-fault" threshold could make more people eligible for benefits. Compensable events might include a very broad class of events arising out of encounters with medical professionals or facilities such as "treatment injuries" (as in New Zealand), "undesired" or "unexpected" outcomes," or "avoidable" injuries (as in Sweden).[33]

[32] One member of the Task Force dissents from this recommendation. He believes that the elimination of the jury system for adjudicating claims of medical negligence should not be considered—no matter what the trade-offs.

[33] One member of the Task Force suggests that instead of changing the definition of the harm or wrong for which the administrative system provides a remedy, the medical negligence standard could be retained while reducing the burden of proof from the "preponderance of the evidence" to something less such as

- The system would compensate victims for both economic damages and non-economic damages caused by the injury.

- The administrative system would be the exclusive remedy for events that are compensable under the administrative scheme. Individuals injured as a result of medical negligence could no longer bring a suit for negligence in court.

The study should also examine whether a voluntary program can be designed that allows individuals to opt into or out of an administrative adjudication system while achieving the system change objectives of the proposal and managing costs.

A host of system design issues would need to be considered in both the primary study and consideration of voluntary program options. (For a list of some of the design issues that should be studied, see Appendix 6.)

The study should address, first and foremost, the impact of each design choice on the value of the administrative system for achieving the goals for system improvement and the key questions identified by the Task Force at the outset of its work and whether the cost of such a system is sustainable.

D. Timing of the study

For years, Oregonians have discussed the merits and demerits of the medical liability system in the context of proposed legislation and proposed ballot measures to change the system. It is critically important to ground this discussion in fact. A professional study of the feasibility of establishing an administrative compensation system and the effectiveness of such a system as compared with the existing one for improving patient safety, improving access to compensation for injured patients, and reducing collateral costs of the medical liability system will be challenging but, if well done, it will serve the state well. The study should be funded as soon as possible—either by the Legislature or by other parties whose funding would not bias the project.

VIII. Conclusion

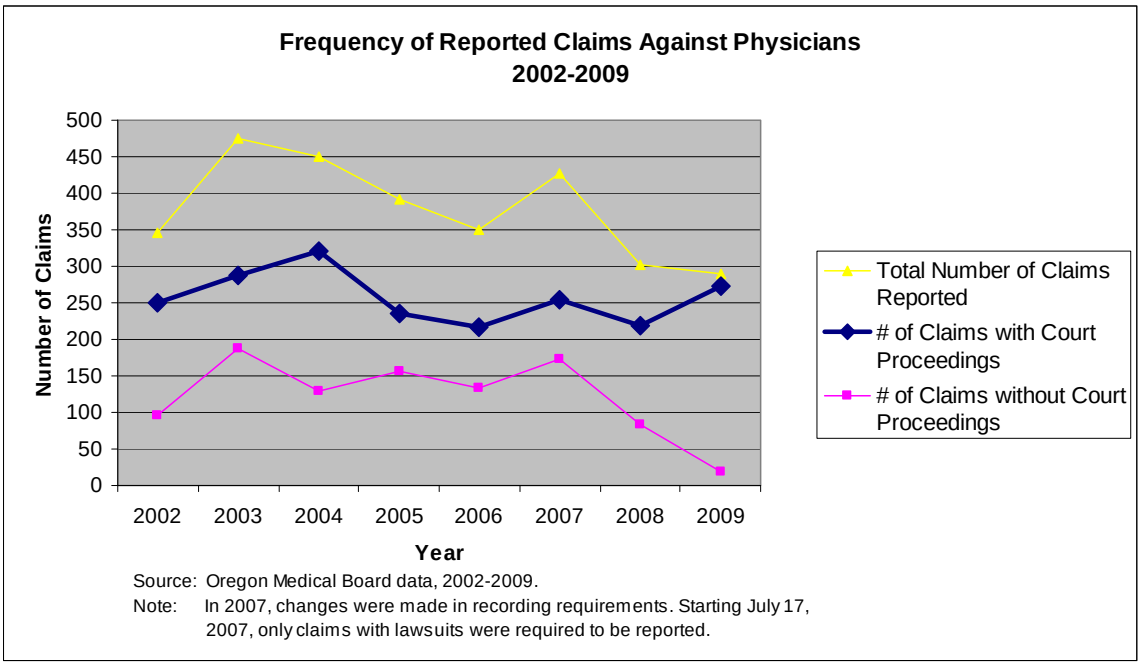
"substantial evidence." Note, however, that the burden of proof applicable to lawsuits for negligence is the same "preponderance of the evidence" standard that is generally employed by finders of fact in Oregon's administrative agencies; the "substantial evidence" standard is used by reviewing courts to determine whether or not the evidence is sufficient to sustain the decision of an administrative finder of fact. See Armstrong v. Asten-Hill Co., 90 Or App 200 (1988)(defining substantial evidence) and Gallant v. Board of Medical Examiners, 159 Or App 175 (1999)(discussing the concepts of burden of proof and standard of review).

The Task Force appreciates the opportunity to study this issue. The recommendations are designed to further the goals of improving patient safety, improving the system for compensating injuries sustained as a result of medical errors, and reducing insurance administration, litigation, and defensive medicine costs associated with the medical liability system.

The Task Force hopes that the effort to achieve these goals will continue by adoption of these recommendations, including the development of legislative proposals relating to disclosure, full exploration of the evidence-based guideline safe harbor concept, and commissioning of a study of the design and feasibility of an administrative substitute for the medical liability system.

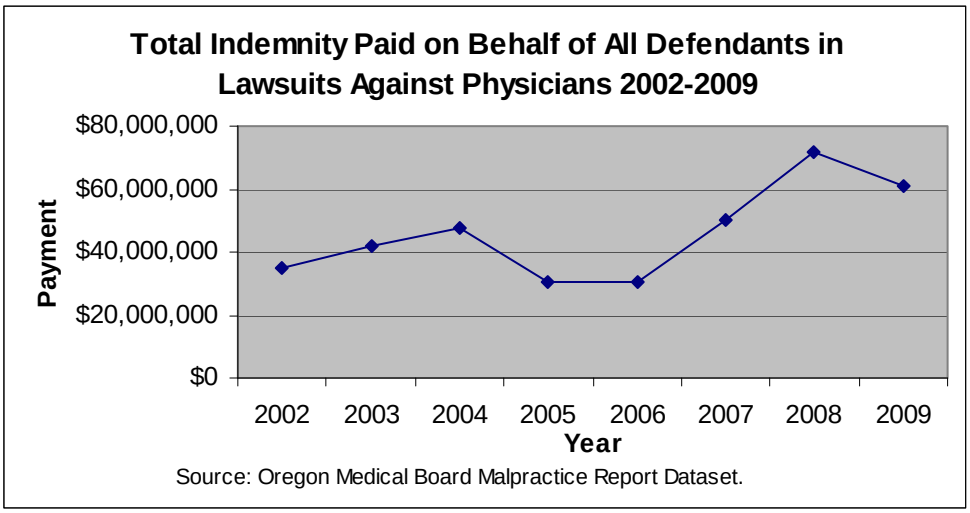
Appendix 1. Liability Cost Trends

The cost of indemnity payments is a function of the frequency of claims and average payment amounts. In Oregon, the frequency of claims filed against physicians in court that have been reported to the Oregon Medical Board has been somewhat volatile in the last few years; on balance, however, although Oregon's population has grown, there has been no apparent upward trend. (See chart below.)



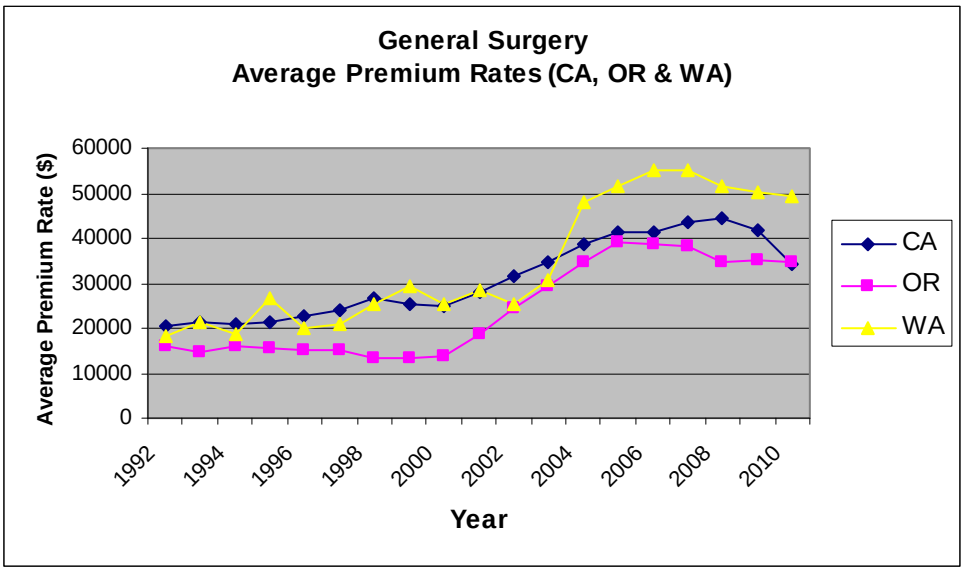
The number of paid claims against professionals reported to the National Practitioner Data Bank surged in 2008; but until data is in for 2009 and 2010, long term trends will not be clear. (See chart below)

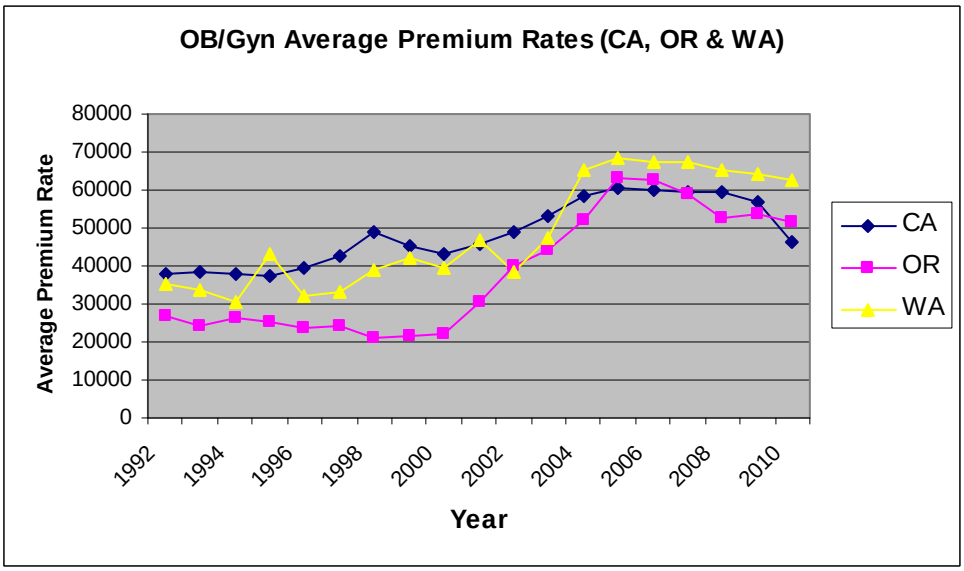
The trend is not clear with respect to dollar amount of payments. In a report issued in February 2008, the Oregon Medical Association and CNA HealthPro reported that the average indemnity amount paid in physician claims declined more than 7.5 percent from July 1, 1999 – October 10, 2005 to October 11, 2005 – October 10, 2007. There is some indication in the Oregon Medical Board data, however, that total payments made in cases filed in court against physicians (and others) is rising. See chart below.



Appendix 2. Trends in Physician Premiums for Medical Liability Insurance

Medical liability premiums for the three physician specialties are reported in the Medical Liability Monitor, the pre-eminent industry publication. OHPR staff averaged the reported premium rates for each state by year and prepared the graphs below.





Notes: The Medical Liability Monitor surveys major writers of professional liability insurance for physicians each year. The survey includes manual rates for specific mature claims-made specialties with limits of $1 million/$3 million (the most common limits). The Monitor reports on three specialties only to reflect the wide range of rates charged: internal medicine, general surgery and obstetrics/gynecology. The rates are the reported rates unless otherwise noted and should not be interpreted as the actual premiums an individual

physician pays for coverage. They do not reflect credits, debits dividends or other factors that may reduce or increase premiums. Rates reported also do not include other underwriting factors that can increase premiums. It is estimated that the survey represents companies that comprise 65 to 75 percent of the market nationally.

Appendix 3. Testimony Concerning the Medical Liability Premium Subsidy Program

Before the
Senate and House Interim Committees on Judiciary
May 24, 2010

Testimony of
Cory Stresinger, Director
Department of Consumer Business Services

My name is Cory Stresinger. I am the Director of the Department of Consumer and Business Services. I am here today to update the Committees on the program that subsidizes medical professional liability insurance costs for rural doctors.

The program began with enactment of House Bill 3630 in 2003. The goal of the program was to assist in attracting and retaining doctors in rural Oregon, and particularly doctors who provide obstetric services. The legislation was the result of escalating concern about the availability and affordability of medical professional liability insurance, particularly for rural doctors who provide obstetric services.

House Bill 3630 directed the State Accident Insurance Fund Corporation (SAIF) to establish a reinsurance program for medical professional liability insurance policies issued to rural doctors. The program was successful in providing medical liability insurance rate relief to rural doctors, and in 2007, the legislature enacted Senate Bill 183 to extend and modify the program for an additional four years, through 2011, but within the original funding limit set in 2003.

In recognition of the role played by nurse practitioners in providing medical care in rural Oregon, the program was expanded to include some nurse practitioners who have a rural practice. In addition, the definition of qualifying "rural" area was modified to exclude areas considered "urbanized" by U.S. Census definitions such as Ashland (except for those doctors and nurse practitioners who provide obstetric care). Also, in order to be eligible for the program, doctors and nurse practitioners had to be willing to serve Medicare and Medicaid patients.

The program continues to prioritize obstetric care, and those who practice obstetrics continue to receive the highest subsidies – 80 percent for obstetricians and nurse practitioners certified for obstetric care and 60 percent for family practitioners or general practitioners whose practice includes obstetrics. Doctors and nurse practitioners in specified primary care fields such as pediatrics and family practice receive subsidies up to 40 percent, while subsidies for doctors and nurse practitioners in non-primary care fields decline over the four year period from not more than 35 percent in 2008, to 25 percent in 2009, and to 15 percent in 2010 and 2011, based on available funds.

Attached are the expenditures by year for the program, as well as data showing the total number of medical providers participating in the program since its inception and the number of providers participating by county. A total of about $29.1 million has been spent through calendar year 2009. Enrollment during 2009 was 881, consisting of 827 doctors and 54 nurse practitioners, and SAIF expended about $3.7 million for calendar year 2009. Enrollment for the first quarter of 2010 is currently 753 doctors and 48 nurse practitioners. The number of doctors and nurse practitioners receiving subsidies in a given year may not equal the enrollment for that year for various reasons. For example, requests for subsidies may not occur in the same calendar year in which the subsidy was provided.

The funding for the program came from credit against workers' compensation assessments paid by SAIF. These assessments are collected from Oregon employers for administration of Oregon's workers compensation system. Under the law, the program costs were capped at $40 million, based on a one-time surplus in this workers' compensation account. However, that surplus has long since gone and this account is not a sustainable source of funding for this program, although there will be sufficient funds available for the last two years.

The program continues to provide medical professional liability insurance rate relief for both rural doctors and nurse practitioners. It should be noted that the medical professional liability insurance market tends to by cyclical, and rates have been declining in recent years. Rates for Oregon's two largest insurers have gone down an average of 20 percent since 2006:

Year	NPIC/Doctors Company*	CNA
2006	-8.3%	1.9%
2007	-10.2%	-3.2%
2008	-8.9%	-7.6%
2009	0%	-2.5%
2010	-5.1%	0%

*Prior to 2010, coverage was through Northwest Physicians Insurance Company. Beginning in 2009, coverage was through The Doctors Company, Northwest Physicians Insurance Company's parent.

The program is scheduled to sunset at the end of 2011.

Rural Medical Liability Financial Reinsurance Plan
Plan Results for 2004 - 2009
By Medical Provider Specialty

Program Expenditures by Year							
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**Total**
Obstetricians	$1,114,027	$1,322,013	$1,440,071	$1,269,246	$1,349,518	$1,183,017	$7,677,892
Family Practice with Obstetrics	$591,524	$629,147	$645,169	$602,271	$506,395	$501,134	$3,475,640
40% Specialties	$2,995,327	$3,445,771	$3,575,492	$3,446,355	$1,400,897	$1,271,826	$16,135,668
All Other Providers	N/A	N/A	N/A	N/A	$1,075,669	$728,929	$1,804,598
Total	$4,700,878	$5,396,931	$5,660,732	$5,317,872	$4,332,479	$3,684,906	$29,093,798

Total Number of Medical Providers Participating in Program						
Through Years Ending:	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Obstetricians	49	54	71	77	44	51
Family Practice with Obstetrics	70	71	73	84	64	59
40% Specialties	935	980	1,024	1,136	512	479
All Other Providers	N/A	N/A	N/A	N/A	316	293
Total	1,054	1,105	1,168	1,297	936	882

Notes: 2008 data include 46 nurse practitioners. 2009 data include 54 nurse practitioners. Prior to January 1, 2008, the "40% Specialties" and "All Other Doctors" categories were combined in one "40%" category. 2004 excludes $200,000 for actuarial study.

Subsidy Percentages by County
As of December 31, 2009

% Subsidy	80%	60%	40%	25%	Total by County
Total	51	59	479	293	882
Frontier	3	13	38	19	73
Baker		2	9	2	13
Gilliam	0	0	0	0	0
Grant		1			1
Harney		2	3		5
Lake		4	1		5
Malheur	3		17	16	36
Morrow			2		2
Sherman	0	0	0	0	0
Wallowa		4	6	1	11
Wheeler	0	0	0	0	0
Rural	42	26	379	263	710
Clatsop			16	11	27
Columbia			1		1
Coos	7	2	61	35	105
Crook		2	6		8
Curry			9	1	10
Douglas	6	1	59	44	110
Hood River	3	6	12	14	35
Jefferson		4	2		6
Josephine	7	3	65	34	109
Klamath	5	4	38	28	75
Lincoln	1		19	4	24
Polk		1	10	1	12
Tillamook	2	2	12	8	24
Umatilla	3		31	18	52
Union		1	9	11	21
Wasco	3		4	20	27
Yamhill	5		25	34	64
Mixed	6	20	62	11	99
Benton			1		1
Clackamas		1	11		12
Deschutes		4	24	2	30
Jackson		4	4	1	9
Lane			6	1	7
Linn			1	2	3
Marion	6	11	15	5	37
Washington	0	0	0	0	0
Urban	0	0	0	0	0
Multnomah					0

Appendix 4. Proposed Addition to Oregon's Insurance Code

(1)

(a) "Adverse event" means a negative consequence of patient care that is unanticipated, is usually preventable and results in or presents a significant risk of patient injury.

(b) "Claim" means a written demand for restitution for an injury alleged to have been caused by the medical negligence of a health practitioner or licensed health care facility.

(c) "Health practitioner" means a person described in ORS 31.740 (1).

(2) An insurer may not decline or refuse to defend a health practitioner or a health care facility against a claim arising from an adverse event for any reason that is based on the disclosure to the patient or the patient's family by the health practitioner or facility of the adverse event or information relating to the cause of the adverse event.

Appendix 5. State Medical Error Disclosure Laws

State	Oregon	Pennsylvania
Covered entities	hospitals, ASCs, dialysis centers, nursing homes, and pharmacies (voluntary)	Hospitals, ASCs, and birth centers (mandatory)
What must be reported?	Serious adverse events specified by rule--e.g., in the case of hospitals, "any unanticipated, usually preventable consequence of patient care that results in patient death or serious physical injury, including the events described in Appendix A"	Serious events, incidents, and infrastructure failures. A serious event is "an event, occurrence or situation involving the clinical care of a patient…that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient." An incident--like a serious event--compromises patient safety, but it does not result in unanticipated injury or require the delivery of additional health services. An infrastructure failure is "an undesirable or unintended event, occurrence or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety."
What must be disclosed?	Reportable events [See reporting requirement.]	Serious events [For definition see reporting requirement.]
How?	in writing	In writing
When?	in a timely way	Within 7 days of the event
Who is responsible?	the facility	The facility is responsible for disclosure; health care workers (includes facility employees and physicians authorized to practice in the facility) must report.

State	New Jersey	California	Florida
Covered entities	all health facilities including outpatient clinics, labs, and pharmacies	Hospitals (mandatory)	Hospitals, ASCs, mobile surgery facilities, and licensed health care practitioners (mandatory)
What must be reported?	Serious preventable adverse events. A serious preventable adverse events is "an event that is a negative consequence of care that results in unintended injury or illness" AND "could have been anticipated and prepared against, but occurs because of an error or other system failure" AND "results in death or loss of a body part, or disability of loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility"	Adverse events (multipage definition which tends toward events resulting in death or serious (but not necessarily permanent) disability.	"Adverse incidents that result in serious harm to the patient." Adverse incident means "an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred" AND which had one of a laundry list of rather serious consequences.
What must be disclosed?	Serious preventable adverse events and allergic reactions. [For definition see reporting requirement.] OR An adverse event defined as "an event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable" that involves an allergic reaction.	Adverse events [For definition see reporting requirement.]	"Serious adverse incidents" [Undefined, but see definition of adverse incident in reporting section.]
How?	In person if patient in facility; by telephone if patient is no longer in the facility and a face-to-face meeting cannot be arranged; by certified mail if facility cannot contact the patient by phone. Contents of the notification must be documented in the patient's medical record.	"inform"	"inform"
When?	No later than the end of the episode of care	By the time the report is due (within 5 days after the error was detected)	"as soon as practicable"
Who is responsible?	the facility	The facility	Facilities and licensed providers

State	Vermont	Washington
Covered entities	Hospitals (mandatory)	Hospitals (mandatory)
What must be reported?	"Adverse events" that by rule must be reported. (Rule adopts NQF list) "Adverse event" is defined as "any untoward incident, therapeutic misadventure, iatrogenic injury, or other undesirable occurrence directly associated with care or services provided by a health care provider or health facility"	?
What must be disclosed?	"Adverse events" that cause "death or serious bodily injury."	Only requirement is for hospital to have a policy in place to assure that "when appropriate, Information about unanticipated outcomes is provided"
How?	"disclose"	unspecified
When?	unspecified	unspecified
Who is responsible?	The hospital	The hospital

Appendix 6. Recommended Study.

The feasibility study should address the following design issues, among others. It should identify alternative design choices and evaluate their impact on objectives identified in the Task Force's framework for medical liability reform:

- Compensability standard: What options are there for defining the injuries to be covered by the system?

- Filing of claims: Should claims be considered only if filed by the injured patient or her representative or family? Should providers be required to affirmatively advise the patient of any medical event that meets the threshold for a claim for benefits and direct her to the agency that processes claims as in other systems? Should providers be required to file such claims on behalf of the injured patient as in the workers compensation system?

- Economic Losses: What losses will be reimbursed?
    - Medical Costs: Will compensable losses include medical costs as they do in the workers' compensation system or should all financial responsibility for medical costs related to the injury be borne by the health insurer and/or the injured patient? If medical costs are compensable, how will responsibility for those costs be apportioned and determined? Should responsibility be apportioned in the administrative proceeding, with the collateral source rule abolished? Or should it be the responsibility of the fund to collect from a health insurer without involving the injured patient?
    - Death benefits: Should death benefits be payable? Is the workers compensation system a good model?
    - Lump sum payment or ongoing responsibility for losses: Will losses—such as predicted costs of medical care, non-medical care such as home care or skilled nursing care, and lost wages—be paid in a lump sum or will losses be paid by the administrative system on an on-going basis? If on an ongoing basis, who will decide what needs are related to the injury and determine what services are necessary and what will be paid for them? Will expenses be reimbursed to the patient or paid directly by the system?

- Non-economic Losses: Should non-economic damages be paid according to a schedule? How will schedules be established and updated?

- Responsibility: How will the administrative system interface with the tort system in cases in which someone other than a professional or a healthcare institution bears some responsibility for the injury (e.g., defective medical device)?

- Administration: Will there still be insurance carriers that accept or deny and pay claims? Will there be a single state fund out of which claims are paid?

- Financing: Who will pay for the administrative/adjudicative apparatus? Who will pay for the cost of claims?

- Attorney fees: How will injured patients' lawyers be paid? (By the system? Out of the injured patients' recovery?

- Appeals: Who may appeal an adverse determination by the administrative adjudicator? Should the appeal be taken to the court of appeals in the same manner and reviewed under the same standard as decisions in contested cases? Who should pay costs on appeal?

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The study should address the specific questions listed below:

- Patient Safety
  - What is the likely effect of replacing the medical liability system with an administrative compensation system on patient safety?
  - Will it create more or less incentive for health care providers and facilities to invest in prevention of medical errors?
  - Will the effect on safety incentives depend on how the system is financed?
  - Will the proposed change support the safety improvement infrastructure more or less effectively?
  - Will some administrative system designs support patient safety improvement more effectively than others?

- Access to and adequacy of payment
  - What is its likely effect on access to and amounts of compensation for patient injury?
  - How would the choice of compensability standard and other design choices affect numbers of injured individuals compensated or amounts of recovery?
  - Who will suffer as a consequence of any payment reductions?

- Relationship to the health care system and health insurance costs
  - How will an administrative program affect health insurance costs?
  - How will it affect the practice of defensive medicine?

- Federal issues
  - Is ERISA implicated by an administrative program?
  - How would federal payers interact with it?
  - Would they have liens against recoveries?

- State constitutional issues (right to jury trial and right to remedy)
  - Can an administrative program be implemented to replace the tort system without statutory or constitutional changes?
  - If not, what changes are necessary?
  - Will some system designs pass constitutional muster and others not?

- Financial feasibility
  - What are the anticipated total costs of the program?
  - How do those costs compare to those of the current system?

- Political feasibility
  - Are health care providers and institutions that currently take direct responsibility for paying for the current liability system in the form of premiums willing to finance the new administrative system? If not, who is?
  - Who can be expected to support or oppose the concept?[34]

[34] Replacing the current system with an administrative one would both eliminate jury trials and limit damages to the extent that compensation is scheduled in some way. Although the ultimate reaction of any group to the results of a study cannot be predicted with certainty, it can be anticipated that trial lawyers who represent injured Oregonians and other groups who have opposed previous efforts to impose caps on damages may view an administrative substitute for the right to a jury trial for negligence as an assault on fundamental rights and vigorously oppose it.

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Health System Transformation Team
Summary of Comments on Draft Legislative Concept
As of 3/9/2011

Definition and scope of ACOs

- *Clarity of definition:*
  - Concerns that description of ACO is too vague and does not include adequate reference to risk bearing.
  - Request to clearly differentiate between standards/definitions of ACOs that will serve Medicaid, Medicare, dual- and triple-eligibles and other market segments.
- *Governance:* Concern over what or who decides what is covered.
  - Involvement of local entities:
    - Request to involve a County Commissioner and/or the Association of Oregon Counties in the work.
    - Support for specific requirements for ACO to establish formal relationship with county public health and mental health agencies in order to capitalize on county assets to achieve triple aim.
  - Legislation should explicitly encourage collaboration with local communities and government entities while clarifying OHA oversight.
- *Geography and number of ACOs*
  - Should the legislation specify an appropriate number of ACOs for each region, weighing the population and provider base (e.g. one ACO for every 50,000 covered lives in a region)?
  - Further clarification requested of how this proposal would impact all parts of the state, particularly those outside of the I-5 corridor.
- *Consumer concerns:*
  - Request to clarify if ACOs are mandatory or voluntary for (a) Medicaid, (b) Medicare and (c) the dual eligibles. Will there be choice among ACOs? If so, what's the minimum number of ACOs for each region or community of the state?
  - Request for language around patient activation/engagement and patient advocates/system navigators
  - Requests for further clarification of the rights and remedies consumers will have and the process by which they will be allowed to exercise these rights.
- *Provider networks:* What standards will ACOs be held to in the creation and maintenance of their provider networks? Can providers belong to multiple ACOs?
- *Building off current efforts:* Suggestion for stronger and clearer language that ACOs will build on and add value to ongoing local integration efforts. Concern that defining the ACO as "single

integrated organizations" will cause an upheaval of existing integrative projects developed in most communities.

- *Benefit coverage and definitions:* Concerns expressed that references to transitional care are too limited and long-term care and supports are too vague.

Integration concerns

- *Evidence base*: Questions regarding the evidence that the proposed approach will improve care, reduce costs, work well across all regions in the state, maintain or improve partnerships and correctly align financial incentives.
- *Approach:* Concern that integration of care occurs at the delivery system level, not with the entity through which the financing flows. Urge focus on outcomes as the objective not a specific structure unless there is a strong evidence base.
- *Definition:* Concern that no explicit definition of what integration means – what kind of relationships define integration?
- *Long-term care integration:* Concern that integration will move long term care from a successful social model into a medical model. Consideration should be given to the best way to coordinate care between a social long term care case manager and an individual's medical primary care home.
- *Mental health integration:* What is the relationship of the ACOs to civil commitment and community mental health/local MH authority to support integration?
- *Reproductive health integration:* Request for Reproductive health to be explicitly listed as element to be integrated along with others.

Global budget & payment incentives

- Request for more discussion and specificity on the term "global budget".
- Request for explicit language that says ACOs and their providers will share in any state-federal shared savings.
- Note that there is no mention of actuarial soundness of the single global payment.
- Concern that global budget may work in some parts of the states easier than others.
- Concern that new entities could set provider rates low and continue a two-tiered system with a public model that underpays for services because the public budget just doesn't exist to pay fairly.
- Comments that payment and incentives should reward the provision of community-based supports for self-management of chronic diseases, engagement with community partners in policy development that addresses the factors that cause ill health and create the need for health care.
- Request that legislation be specific regarding risk-adjustment mechanisms.

- Concern that incentives for the development of specialty services does not result in duplication of services and new costs to the total system. Should regional ACO's could be required or strongly incentivized to refer to centers with adequate volume and existing delivery platforms?

Accountability and metrics

- More description of quality standards requested because of their importance. Request that at minimum list credible authority that program would use as source for the standards, and specify method and frequency of evaluation.
- Encouraged strong financial oversight of the ACOs by OHA using clearly understood standards.
- For accountability and health equity, suggested language be included that describes how overall health in an area is measured and to what standard of health the ACO will be held responsible.
- Requests that measures on consumer satisfaction, reductions in disparities in access and outcomes, timely access to care, and risk factors for the major drivers of ill health (especially chronic disease and injuries) should be referenced in the collection of quality information.
- Requested need for clarity regarding how collected measures will be used to ensure accountability if deficiencies are detected.
- Request for clearer definition of accountability. "Population accountability" could be defined.
- Suggestion that OHA develop standards and clearer expectations for some of the community-based supports that ACOs and primary care homes might link to (e.g. worksite wellness programs, chronic disease self-management resources, involvement of community health workers)

Implementation concerns

- *Feasibility:* Concerns voiced regarding the speed of implementation necessitated by the fiscal crisis, the ability of local health care "systems" to quickly adapt care delivery and financial systems, the ability of the State to effectively and even-handily manage performance-based contracts of a complexity unknown to them, and the likelihood of necessary federal approval.
- *Clarity of direction:* Concerns expressed that framework is not concrete enough to provide a clear path. How is this approach a platform for organizing reform across the private sector as well? Concern expressed that limiting the scope of this proposal to just Medicaid eligibles continues to leave lives outside the system and thus the pressure of cost shifting.
- *Reducing burden:* Request for explicit language about reducing regulatory and administrative burden, including mirroring federal standards, certification, and reporting where possible.
- *Provider training:* Support expressed for the development of provider knowledge, skills, and attitudes for doing integrated health care to support integration.
- *Drafting the RFP:* Request that provider networks along with representatives from the consumers, community social services, local government and public health be involved in drafting an RFP

- *Phased approach:* Request for a phased or more gradual implementation timeline, including rolling acceptance of ACO proposals and 2014 as the target date for mature ACOs in each region

Federal approvals or waivers

- Concern that federal approvals for Medicare should be clear on the populations included (duals, all, another subset) and the nature of the waivers (such as restrictions on choice).
- In addition to approvals listed, OHA could seek federal approvals to use Medicaid or Medicare funding streams for population health or public health services
- Request that legislation be clear regarding need for waivers to provide safe harbor from federal statutes and regulations which act as barriers to clinical integration and provider collaboration needed to facilitate formation of ACOs.

Elements not included in the draft LC and other comments

- Does tort reform needs to be in the mix of changes proposed? Recommendations on maximum liability exposure for ACO and its providers that comply with evidence-based protocols, practice standards, and shared decision-making.
- Concern that a viable safety net is still needed in addition to the Accountable Care Organizations and their covered members and that Federally Qualified Health Centers provide integrated health homes should have a clear role.
- Concern that current LC does not touch on social conditions outside of health care such as housing that critically impact health outcomes.
- Request that language should be added that health care systems should participate meaningfully in efforts to address drivers of health in their communities.
- Proposed additions to LC language regarding system and ACO attention to the drivers of ill health.
- Request for a clear a definition of regional health authorities that is openly discussed with broad input to determine boundaries, authority and characteristics of regional health authorities.
- Request for the RFP process should include a conscience clause provision to allow organizations with religious or moral limitations to participate while still serving their missions.
- Suggested LC language for this section regarding ACO responsibilities when medical errors occur.
- Suggest adding “avoidable” to the reference to reduction of the use of ER and hospital readmissions.
- Concern that concept protects information sharing for public health activities required by law.

AN OREGON SOLUTION:
THE OREGON PEER WELLNESS COACH PROJECT:

"PROJECT DOING WELL"

Key concepts:

Peer Wellness Coaches offer an efficient means to engage persons who have lived experience of mental health issues who are able and willing to give back to their communities to support peers who have chronic diseases and to prevent chronic problems from developing when possible.

Wellness Coaches will work in clinics and in the community settings with clients who have dual eligibility to help them create and maintain optimal wellness and will help prevent situations that require more intensive levels of care.

Training and technical assistance will be organized and implemented at the sate level and reach both urban and rural health programs, as well as disparity populations.

BACKGROUND:
Certified Peer Specialists (CPS) are persons who are in recovery from mental health issues who choose to undergo specialized training so that they can "give back" and help their peers with support and advocacy with the goal of their being able to live independent, meaningful and satisfying lives in their communities.
The Peer Wellness Specialist Program of Benton County was the first program in Oregon to be approved by the state to offer certification to its graduates. The training has been used with students in five counties, spanning the cascades to the coast.
In addition, the training is part of the Friends4Recovery and Wellness Center in Virginia.
The training is designed to train certified peer specialists in all of the core competencies of the state Addictions and Mental Health requirements, but it goes further in order to create an experience for students that is transformational and supportive of an enhanced personal recovery, interpersonal workforce bonding, and the cultivation of leadership skills. The training itself consists of eleven weeks of weekly four-hour sessions for a total of 44 hours. In addition, peer specialist students must attend and create their own student led weekly "process groups" that last two hours per week for a total of 22 hours over the course of the training. These groups are student led and are a bonding experience that is designed to continue after the training is over, as support groups for the new peer specialist workforce. Subjects include but are not limited to health literacy, advocacy, recovery, trauma-informed care, group facilitation, an overview of mental health and substance use diagnostic categories, crisis intervention, and development of leadership and problem solving skills

After completing the Peer Wellness Specialist training, the certified peer specialists (CPS) attend regular in-services and clinical supervisions to hone their clinical skills and to be in compliance with Medicaid standards. Benton County Peer Specialists encounter Medicaid for their services and are trained in the use of the electronic medical records system, CPS work with clients in the community, as well as in the health clinic, serving peer clients in skills building, advocacy, wellness support, and an array of other services, including the LOTUS Wellness Support group, the Veteran's Peer Support Group, the Mindfulness (stress reduction) group, Dual Diagnosis Anonymous, as well as Living Well with Chronic Diseases.
Subsequent to completing the peer wellness specialist training and working as certified peer specialists, CPS' have the option to attend advanced training in the Peer Wellness Coach Program.
CPS work as paid employees with the mental health team of the community health center. There is also a volunteer Senior Peer Support Program that utilizes trained senior citizens to help one another with problems of living that are especially common among seniors, such as personal loss and depression.

Peer Wellness Coach Program.

The Peer Wellness Coach Program includes a 44-hour training designed to teach skills to certified peer specialists that can be used to help peer-clients successfully self-manage medical problems, especially chronic disease. Peer Wellness Coaches work with multi-disciplinary teams in a person-centered, integrated health home. This type of service is consistent with the direction of federal and state health system development.

The goal of Peer Wellness Coach Training provides participants with a basic understanding of health issues and techniques that Wellness Coaches will use in their work.

As a member of a Person Centered Medical Home Care Team, Peer Wellness Coaches support people who have mental health and significant physical health needs in creating wellness-oriented lifestyles. The work is also preventative to help keep persons with mental health challenges form developing chronic diseases. The Peer Wellness Coach helps people get information, identify self-management goals, and assists people in navigating the mental and physical health care systems, according to the person's needs and choices.
One of the goals of peer wellness coach services is to help peer-clients get care and support before chronic conditions are at emergency levels, avoiding trips to the emergency department and/or hospitalizations. some of this work will occur in the clinic setting, but also wellness coaches work

with peer –clients in the community, at their residences and accessing community health supports and organizations.

The training includes presentations by people with subject matter expertise, in -class activities, as well as out of class activities.

Peer Wellness Coach training is open to persons who have successfully completed the Peer Wellness Specialist Training. At the end of this 44-hour, 11week training, people who have successfully completed the training will receive a certificate of completion.

PEER WELLNESS COACH PROGRAM FOR OREGON: THE "DOING WELL PROJECT"

The DOING WELL PROJECT would be a systemic approach to design and implementation of Peer Wellness Coaching at the state level.
The state Doing Well Project would look to state and federal sources for funding, including the Center for Medicaid Services Center for Innovation.

The DONG WELL PROJECT would be a peer –run group of peer wellness coach trainers, led by a project director, who would be available to assist community health programs train and implement peer wellness coach programs as well as coordinating senior peer support training. **The Doing Well Project would provide training and technical assistance across the state, from metropolitan areas to rural communities.**

The Doing Well Project would also include an ombudsperson function in which persons that are mental health and physical health care recipients, (persons who are dually –eligible) could take complaints and problems for peer support and problem solving. The goal would be to help clients of community services find solutions to problems they might encounter through the services organized around peer support and advocacy. **Goals would include increased patient satisfaction and the solution of problems in a non-litigious arena.**

Outcomes would be evaluated to confirm that clients were getting care before their problems require more intensive levels of service, such as the emergency department and in-patient care.
Client satisfaction would also be evaluated to make certain that clients were getting the help that they feel they need and desire.

CURRICULUM-trainers: PEER WELLNESS PROGRAM

Benton County, Oregon

UNIT 1: Welcome to the Role of Peer Specialist

1. Overview of program
2. What does a Peer Wellness Specialist do?
3. Cultivating a positive attitude
    a. Practicing mindfulness
    b. Working with relaxation techniques
    c. By oneself
    d. With peers
4. Problem-solving tactics:
    a. Assertive
    b. Passive
    c. Aggressive
5. Being "triggered": what to do when "issues" come up
6. What is "recovery"?

UNIT 2: Taking Care of Self and Others

1. Creating a wellness lifestyle for oneself
    a. Self-care 101
    b. Self-care tool box
    c. Personal safety
2. Supporting wellness for peers
    a. Creating a "Wellness Culture"
    b. Health literacy-what it is—how to get it and spread it
3. Implementing the LOTUS Wellness Support Group
4. Recovery – Introduction

UNIT 3: Recovery, Wellness, and Working Skillfully with "The System"

1. Values of the Recovery Model
2. Medical Model concepts and how to use them
3. How to work with medical staff
    a. working with clinicians as colleagues
    b. being an advocate for our peers with providers
    c. how to solve problems with providers
    d. writing cases notes—documentation

4. Bringing wellness into systems:
    a. promoting the Wellness Pledge and wellness policies
5. How clients can get medical records
6. The empowered use of medications

UNIT 4: Work Issues – The Profession and Ethics

1. Codes of professionalism
    a. Ethics
    b. HIPAA
    c. Standards of conduct
    d. Mandatory reporting
2. Boundaries
    a. Setting limits
    b. Defining personal space

UNIT 5: Work Issues 1. Solving problems: Mind States—July 13

1. Manic states
2. Depression
3. Thought disorders: hallucinations, delusions, paranoia
4. Anxiety
5. Young Adults in Transition –how to be supportive
6. Addiction issues-
7. Check in --group

UNIT 6: Work Issues 2. Trauma

1. Trauma theory
2. Problem-solving – understanding relapses
    a. Assertive versus passive or aggressive
    b. Warning signs
    c. Role of stress
    d. Precipitating factors
    e. Understanding and working with triggers
    f. 3.

4.) The skillful attitude

5.) Combating stigma, prejudice and discrimination

6.) Working with clinicians in the community mental health /medical setting

UNIT 7: The Law, Medical Terminology, Outcome Measures

1. The Law: Disability – what is it? --
    a. History of disability rights movement---
    b. Laws that are particularly relevant to mental illness—
        i. ADA-Americans with Disabilities Act
        ii. Omlstead Decision
2. The Psychiatric Advance Directive --- What it is, How to do it-
3. Medical terminology
    a. DSM terminology
    b. Outcome measures
    c. Evidence-based practice concepts
        Research terminology

UNIT 8: Being an Advocate; Cultural Competency

1. Cultural competency
    a. How culture can shape the helping process
    b. How communication is shaped by culture
    c. Appreciating cultural diversity in communication styles
2. Crisis Intervention
    a. Identifying the problem
    b. Taking action – getting support
    c. De-escalation techniques
3. When someone is Suicidal--what to do

UNIT 9: Group Facilitation; Communication Skills

1. Basic group facilitation
2. Active listening skills
3. Non-verbal communication
4. Understanding and appreciating diversity in communication styles – personal and cultural
5. Responsibility: the effect that the Peer Wellness Specialist has on peers

UNIT 10: "WRAP" and What's Important

1. Tobacco Issues
2. Creating and using a person-driven plan for yourself and peers

3 “WRAP” (Wellness Recovery Action Plan): What it is and how to do it

4. How to understand and work with Wellness Survey and Wellness Action Plan

UNIT 11: Pulling It All Together; Saying Who We Are; Getting Closure

1. The use of art and movement for peer specialists
2. State and federal legislation: call to action!
    a. Educating legislators
    b. County commissioners and judges
3. Expecting the best: the power of expectation and intention
4. Check in: getting closure
5. GRADUATION!

Peer Wellness Coach Training
Benton County Health Services
Corvallis, Oregon

The goal of Wellness Coach Training is to provide participants a basic understanding of health issues and techniques that Wellness Coaches will use in their work.

As a member of a Person Centered Medical Home Care Team, Peer Wellness Coaches support people in creating wellness-oriented lifestyles. The Peer Wellness Coach helps people get information, identify self-management goals, and assists people in navigating the mental and physical health care systems, according to the person's needs and choices.

The training will consist of presentations by people with subject matter expertise, in class activities, as well as out of class activities.

Peer Wellness Coach training is open to persons who have successfully completed the Peer Wellness Specialist Training. At the end of this 44-hour, 11week training, people who have successfully completed the training will receive a certificate of completion. Successful completion will be based on:

1. Attendance at each of the assigned classes
2. Participation in the classes, and out of class exercises
3. Demonstrated understanding of key concepts
4. Instructor evaluation and recommendations.

We understand that these topics may be of interest to some people, who may not be interested in getting a certificate of completion. As space allows, persons interested participating in the classes, without receiving a certificate will need approval from the training coordinator.

There will be 11 sessions lasting 4 hours each. Some work outside of the sessions will be required. There will be a group project presentation at the end of the training.

Wellness Coach Training Curriculum

I. Introduction
   a. Welcome
   b. Overview of Training and participant outcomes
   c. What is the problem: Morbidity and Mortality Data: national, State, and local health concerns
   d. Role of the Peer Wellness Coach
   e. Characteristics of a team

II. What does A Peer wellness Coach Do
   a. Principles of Adult Learning
   b. Trauma-informed care and wellness coaching
   c. What is wellness (in class exercise: Why is being a Peer Wellness Coach Important to me? What can I contribute to team based care? What will I need to learn more about?
   d. Recovery, Wellness and Medical Models
   e. Discussion of group project; pick partners.

III. Tobacco use---strategies for supporting tobacco Freedom
   a. Strategies for supporting Tobacco Freedom

Out of class activity. Take home quiz.

IV. Chronic Conditions
   a. Overview of Chronic Diseases and their Impact on health
      1. Heart Disease
      2. Pulmonary Disease
      3. Diabetes

V. Chronic Conditions (continued)
      1. Obesity

2. Substance Use
3. Metabolic Syndrome

Out of class activity: Take home quiz

VI. Principles of Person Centered Medical Home
   a. Principles of the Person Centered Medical Home model
   b. Team Based
      1. Who's who and what do they do
   c. Ethics
   d. Peer –based integration of mental and physical health

VII. Elements of a healthy lifestyle
   a. Nutrition and supplements
   b. Exercise and movement
   c. Creativity
   d. Spirituality

VIII. Elements of a health lifestyle (continued)
   a. Community Involvement
   b. Stress management
   c. Dental Care
   d. Financial health
   e. Housing

IX. Strategies for Peer Wellness Coach
   a. The components of a treatment plan: Self management goals
   b. Motivational Interviewing
   c. Conducting peer-led basic health screenings—what and how it is done

      1. blood –pressure
      2. body mass index
      3. tobacco use

X. Strategies (continued)
   a. Cognitive Behavioral Restructuring
   b. Mindfulness
   c. Education, Training and Employment

d. Using natural supports

XI Presentations of Projects
Graduation

Presentation Requirements (Be creative, you can write a paper, do a skit, PowerPoint, collage, write a song, whatever you would like!)

1. A description of the condition
2. Some facts about the condition
3. What are goals for improvement for the condition
4. What are some interventions and resources you might use as a peer wellness coach

Each participant will be asked to set a wellness goal for him/herself for the time they are in the class, and will be asked to write a weekly one-page journal entry describing how s/he is doing on his/her wellness goal.