STATE NEWS

STATES CONSIDER HEALTH COURTS AS A WAY TO REDUCE ERRORS

Christina Kent

A growing number of states are eyeing “health courts” as a potential way to reduce medical errors, improve the science on which legal judgments are based and ensure that truly injured patients receive predictable damages in a timely fashion. Like the drug and mental health courts that have been established in many states across the nation, health courts would focus on a single issue: medical injuries.

Health courts would move medical malpractice lawsuits away from the tort system to a special administrative compensation system, Michelle Mello, assistant professor at the Harvard School of Public Health, said at a recent seminar sponsored by The Robert Wood Johnson Foundation. The idea has been around since the 1970s, but it’s receiving renewed attention as states have sought ways to reduce medical malpractice liability premiums and improve patient safety. A growing number of states—including Colorado, Illinois, Maryland, Massachusetts, Michigan, New Jersey, Pennsylvania, Virginia and Wyoming—have considered bills that would set up health courts or establish commissions to study the issue, but none have led to the establishment of a court.

“I think there’s a real opportunity to do something at the state level on this,” Massachusetts Sen. Robert O’Leary told seminar attendees. “There is an appetite to take up issues that the federal government has been unwilling to take up.”
However, strong and divergent views on medical malpractice exist. “This area is a very tough nut to crack,” said James Ingram, senior counsel at The Robert Wood Johnson Foundation. “Even with strong policies and strong political support, it will be very hard to do.”

In a recent paper in The Milbank Quarterly, Mello and her co-authors noted that health courts have five core features:

- specially trained judges would make injury compensation decisions;
- compensation systems would move from the current negligence standard, to “avoidability”—whether injuries could have been prevented if best practices had been followed;
- compensation criteria would be based on the leading scientific literature;
- this knowledge, coupled with precedent, would allow decisions to be made more quickly than is currently the case; and
- guidelines would help decide the size of economic and non-economic damages.

A health court presents greater possibilities for cost control than the current system, Mello wrote. More claims would be filed, but the average award would likely be lower and the size of the award would be controlled.

Health courts also would help reduce medical errors, advocates say. De-identified information from the adjudication process could be combined with data from the reporting systems that have been enacted by a number of states to produce a centralized repository for health safety data. This information would be aggregated, analyzed and cycled back to providers to improve the science of safety.

There is no guarantee that providers would report all problems, but it’s hoped that by reducing the stigma associated with the current tort system, health courts would encourage the openness that can help reduce errors, Mello said.

**The Keystone State**

In 2002, Pennsylvania enacted a package of significant medical malpractice reforms. Now Sen. Jane Orie and some colleagues want to move on to “phase II,” said Lawrence Feinberg, attorney with the research arm of the Pennsylvania General Assembly.

Earlier this year, Orie introduced a bill (SB1231) that would test an administrative medical liability system. A commission would award up to three grants to self-insured hospitals and affiliated physicians. The providers would agree to a uniform injury compensation schedule, and patients would have the choice of opting into the program. Any attorney fees would be limited to 20 percent of the total award.

Providers would be required to disclose serious events, and the processes that led to the injuries would be analyzed and that information returned to the providers. The participants and the Commonwealth would share the costs of the pilot over its three- to five-year period. Afterward, participating health-care providers would be responsible. The bill was referred to the Judiciary Committee.
States that enact health court laws can expect to be sued, said Edward Dauer, dean emeritus at the University of Denver Sturm College of Law. “I would bet that almost any model would be challenged almost anywhere, so you need to be prepared for that,” he said. The challenge could allege that the health court denied citizens rights guaranteed to them under the state constitution, such as the right to a trial by jury.

The best way to survive a court challenge is to have (1) strong, empirical data that show the existence and severity of existing problems, and (2) evidence that the model that has been enacted would alleviate those problems, he added.

For more information on state health courts, contact Common Good (www.cgood.org), which sponsored the Nov. 8 seminar along with the Harvard School of Public Health.

STATE NEWS

RITE SMILES: IMPROVING ACCESS TO ORAL HEALTH CARE

Anna C. Spencer

On Sept. 1, Rhode Island launched RIte Smiles, a dental program designed to increase access to dental care for children enrolled in RIte Care, the Ocean State’s Medicaid program.

Already, the program is being hailed as a success. Since its inception, the number of dentists participating in Medicaid statewide has jumped from 27 to 129. As of Nov. 1, 30,000 children were enrolled in the program.

Like many other state Medicaid programs, Rhode Island historically has provided dental benefits to Medicaid beneficiaries on a fee-for-service basis. In 1999, at the behest of the Governor, a special Senate Commission on Oral Health was convened. Near the top of the commission’s list of recommendations was improving access to dental care for children.

In 1991, Rhode Island reformed its Medicaid program, establishing RIte Care as a capitated managed-care system. Now the state set out to improve access to dental care for low-income children by extending the same type of delivery system to dental care for kids.

RIte Care’s Dental Benefits Managed Program contracted with UnitedHealthcare Dental to administer RIte Smiles. The program—which is financed through reallocated Medicaid dental funds—delivers oral health services to qualifying children from birth to age six. Children must have been born on or after May 1, 2000, be eligible for medical assistance and not have other dental coverage. RIte Smiles covers a wide variety of types of care, including preventive (cleaning, fluoride), diagnostic, restorative (fillings and crowns), endodontics (root canals), oral surgery (extractions and mouth surgery), orthodontics, periodontal and prosthodontics (specialized replacement of missing teeth).

Focusing on kids birth through six “sets the stage for future oral health,” said Martha Dellapenna, the oral health project manager with the state Department of Health and Human Services. Unlike medical care, people often forego dental care until there is a serious problem, which increases the costs and health risks associated with dental care, she explained. “Getting people to the dentist early and regularly requires dispelling a number of myths and a huge amount of behavior change,” she added.
The UnitedHealthcare Dental program had to be committed to reaching out to the Medicaid community, said Dellapenna. They also had to be willing to work with their own providers to get them to participate in the program; under Rite Smiles, dentists don’t know which young patients are Medicaid beneficiaries and which ones aren’t—their receptionists simply see the UnitedHealthcare Dental card. “There is a lot of reluctance and mistrust on the part of providers about Medicaid patients,” she said. “United has worked very hard with their providers to encourage participation in the program, and the number of dentists willing to see Rite Smiles kids grows every day.” Among other things, UnitedHealthcare Dental does one-on-one recruitment of dentists in their offices, provides continuing education about pediatric dentistry and ensures that dentists get reimbursed more quickly than they did under the fee-for-service system.

Other Activities

In another effort to improve children’s oral health, Rhode Island used a three-year, $740,000 grant from the Robert Wood Johnson Foundation to increase the capacity of dental “safety net” providers in the state, expand Providence Smiles (a school-based prevention program) to additional school districts, and build workforce capacity by increasing the supply of pediatric dentists, dental hygienists and dental assistants in the state.

Prior to the grant, Rhode Island had no dental residency programs. The grant helped to develop two new residency programs that will graduate six dentists in 2007. Providers often remain in-state after their residency programs, increasing the workforce pool. The state also established a seven-week internship program to train individuals participating in the welfare-to-work Family Independence Program to be dental assistants. Finally, Providence Smiles, a mobile dental team that provides examinations, cleanings, sealants and oral health education in schools, was able to hire additional dental professionals to provide care in an expanded number of settings.

“In our effort to improve the oral health of our Medicaid beneficiaries, we opted for the scatter-shot approach,” said Dellapenna. “We tried to cover as many bases as possible.”


STATE NEWS

QUESTIONS ABOUT THE STATE OF HIT

Florida Rep. Holly Benson

Would you please describe your state’s strategy for using health information technology (HIT) to improve the efficiency and quality of health care?

Our biggest HIT initiative is Florida Compare Care (www.floridacomparecare.gov). This website allows consumers to compare all sorts of things, including cost of care, physician licensing information, hospital quality and health plans.
Florida has also taken the lead on Regional Health Information Organizations, or RHIOs. We have used some funds to support the creation of these RHIOs, and have had a lot of early successes in terms of developing databases and tracking patients.

As a compliment [to the RHIOs], we’re planning on launching the Florida Health Information Network. The purpose of this network is to figure what information we have available in state databases and improving the coordination of this information. We’re also working with the private sector to [help us] use existing data better to drive improvements in quality.

In addition, we have given our top 3,000 Medicaid [prescription drug] prescribers PDAs. The devices contain our Medicaid drug formulary, drug interactions and they allow physicians to e-prescribe. So far the program is going very well. I suspect in the next few years you will see a real push in Florida, as well as many other states, to use e-prescribing.

(In 2006, Rep. Benson co-sponsored legislation (HB7073) which, among other things, authorizes the Agency for Health Care Administration to develop an electronic health information network.)

What are the biggest difficulties that you’ve encountered so far, and how are you working to overcome them?

You always want more money than there is available, so limited resources is the first difficulty. Second, because every system has been investing in separate technology the challenge becomes achieving interoperability. You need data systems to talk to each other so that you can make better use of all the data that you’ve captured.

Some experts say that states will be able to restrain rising health-care costs by using HIT to reduce the number of medical errors that occur. Are you tracking medical errors, and if so, how?

If you look at all the old Institute of Medicine reports about patient safety issues, it’s obvious that if you improve health information technology you can reduce errors. This is particularly important with respect to pharmacy issues. It’s been well demonstrated that if you can track people’s prescription drug usage, you can reduce exponentially the number of patient safety issues.

We’re currently reporting patient safety indicators at the hospital level—this information is available on the www.floridacomparecare.com website. In addition, we’re collecting data on “present-at-admission” status, or whether a patient’s diagnosed illness was present when he/she was admitted to the hospital. This data will help determine if there are patient safety issues arise once patients are admitted and enable hospital to address problems when they arise.

A couple of years ago, we established the Florida Patient Safety Corporation, which is a public-private partnership. The corporation is charged with looking at other patient safety measures, though they haven’t released any recommendations yet. We do lots of public-private partnerships in the state because there are an entity that give us a little more flexibility.

Are there any dangers in relying on HIT?

Any time you rely on technology you want to make sure people’s private information is kept private. There continue to be too many reports about data being leaked. [Personal
information] is too valuable to let get into the wrong hands so before you put too much out there in the public domain you have to ensure that all the safety measures, firewalls, etcetera are in place.

You always have worries about system failures but beyond that, I think most patient will view HIT as tremendous value, particularly the high consumers of health care.

**What have you learned so far from Medicaid reform in Florida, and what lessons do you have for other states seeking reform?**

We have found that choice really is important to our Medicaid recipients. One of the key things for other states looking to reform their programs is having good counseling in place.

Another thing, we worked very hard to establish is a competitive market place. Under reform, we finding we have many more health plans serving Medicaid beneficiaries in Broward and Duval County than we ever had prior to Medicaid reform. When you have major undertaking like this, the outreach to the community, the beneficiaries and the providers is crucial. You have to make sure the process is transparent—and transparency is an ongoing obligation.

Finally, I think it’s also important to always look to outside resources and consultants throughout the process for help. They often have different resources than are available within state government. We found that utilizing more formal project management techniques is really essential. There are just certain things you need to get from the private sector about how to run a business that you wouldn’t traditionally tap into.

**GRAPHICALLY SPEAKING**

**MOST STATES DON’T PLAN TO INCREASE COST-SHARING FOR PRESCRIPTION DRUGS**

The Medicare Part D drug benefit has not—at least to date—significantly affected most states’ budgets, according to a new survey of Medicaid officials in 47 states. Fourteen states are paying about the same for drug coverage for “dual eligibles” under Part D as they were when those beneficiaries received that coverage through Medicaid (see chart, below). Twelve states report paying more, and eight states say they’re paying less.

On Jan. 1, 2006, Medicare began covering prescription drugs for the approximately 6.2 million beneficiaries dually eligible for Medicaid and Medicare. In exchange for covering the drug costs of these beneficiaries, states must make payments to Medicare (popularly known as the “clawback”).

Meanwhile, most states report that they don’t expect the Deficit Reduction Act of 2005 (DRA) to significantly reduce their spending on pharmacy benefits. The DRA gave states greater flexibility in how they manage their Medicaid programs, including the ability to increase cost-sharing for prescription drugs. Twenty-three states said they are unlikely to increase cost-sharing (see chart, below).
HIGHLIGHTS

END-OF-LIFE CARE

DNR Directions

The Utah Department of Health has come up with a system to ensure that terminally ill patients who do not want to be resuscitated have their wishes respected when emergency medical service (EMS) responders come to their assistance. From now on, patients who receive approval from their physicians may obtain “Medic Alert” bracelets or necklaces that are inscribed with Do-Not-Resuscitate orders. Provided by the nonprofit Medic Alert Foundation, the devices will give clear and legal directions to EMS responders about the patient’s desire to forego CPR or other life-prolonging measures. “It is a legal way for
choices to be recognized and honored,” said Don Wood, DNR program manager for the department’s Bureau of EMS.

SUBSTANCE ABUSE

Testing Homes

In an effort to prevent illness—and lawsuits—the Bear River Health Department in Utah will inspect homes for methamphetamine-related chemicals for a $150 fee. The program was hatched after a young couple who bought a local house said they suffered headaches, diarrhea and rashes caused by the residue of meth that had been manufactured in the home. They sued the previous owners, a real-estate agent and a realty firm, according to an Associated Press report in the Salt Lake Tribune. “Your main customer will be realtors,” Logan Police Sgt. Bret Randall was quoted as saying. “It’d be the best $150 that realtor will ever spend.”

NURSING SHORTAGE

If You Build It. . .

Idaho Gov. Jim Risch plans to ask the Legislature to forestall an imminent nursing shortage by constructing new nursing education buildings at two state colleges. Last year, 800 qualified people who applied for nursing education in Idaho were turned away because of a shortage of classroom space and faculty. Risch, whose term ends in January, hopes the Legislature will spend more than $37 million to construct the new facilities, according to an article by the Associated Press. Risch said he’s “not totally set in stone on this funding,” but he plans to suggest in his budget address that the Legislature pay for construction by taking $18.5 million from the state’s $208 million surplus and buying 20-year bonds for the rest.

By 2020, the state will have only 40 percent of the nurses needed to care for its aging population, the governor said. Meanwhile, in a recent Health Affairs blog, nursing expert Linda Aiken suggested a number of ways to solve the nursing shortage and debunked seven “myths” about it. Nationwide, she wrote, the nursing shortage will increase to 800,000 by 2020.

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