Four Steps Can Reduce Hospital-Based Malpractice

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Abiding by four practice patterns might avoid nearly two-thirds of the costs of malpractice litigation for hospital-based obstetrics, Dr. Steven L. Clark said in a poster presentation at the annual meeting of the Society for Maternal-Fetal Medicine.

A review of all 189 closed perinatal malpractice claims in one health care system between 2000 and 2005 found that 61% involved substandard care. These accounted for 79% of the approximately $168 million paid out during that period in court judgments or to settle cases out of court, reported Dr. Clark of the Hospital Corporation of America, Nashville, Tenn., and his associates.

Substandard care was defined as practice that was at odds with (or was judged by a treating physician or defense consultant to be at odds with) guidelines published by the American College of Obstetricians and Gynecologists.

Millions of dollars in litigation costs might have been avoided if these four practices had been followed:

► Practicing obstetrics in a facility with 24-hour in-house obstetric coverage. This might have eliminated 23% of cases (and 14% of total litigation costs) related to fetal monitoring for deliveries other than vaginal births after previous C-section (VBACs).

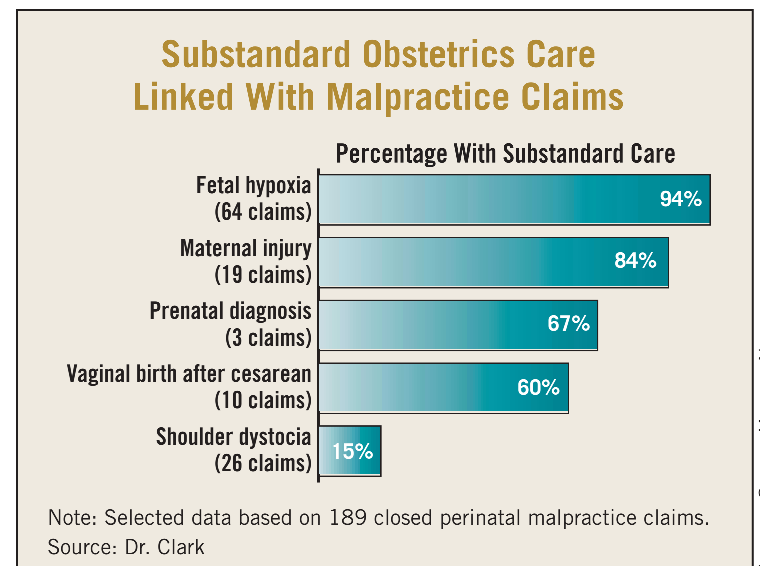
► Adhering to existing checklist-driven protocols for administering oxytocin, misoprostol, and magnesium sulfate. This might have avoided 45% of cases and 27% of total costs related to fetal monitoring in non-VBAC deliveries, as well as 16% of maternal injury cases (and 3% of total costs).

Following either of these first two practices might have avoided an additional 17% of other cases (and 10% of total costs) related to fetal monitoring.

► Taking a more conservative approach to VBAC by limiting VBAC to spontaneous labors progressing without augmentation and without repetitive moderate or severe variable decelerations.

► Using a comprehensive, standardized procedure note for complete and consistent documentation in cases of shoulder dystocia. This could have avoided 54% of fetal losses (and 4% of all litigation costs) associated with shoulder dystocia.

Modest alterations in obstetric practice could significantly reduce allegations of malpractice, the investigators concluded.



Note: Selected data based on 189 closed perinatal malpractice claims.
Source: Dr. Clark

The largest number of malpractice suits (64) were related to fetal hypoxia, and 60 of these involved substandard care.

These cases accounted for the largest share of litigation costs ($89 million). ■

Sustainable Growth Rate Fix Won't Come Cheap or Easy

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — It won't be cheap to fix Medicare's problematic physician pay formula, but lawmakers aren't saving any money by waiting to replace it either, experts testified at a hearing of the Senate Finance Committee.

"We have been kicking this can down the road for the past 5 years. This committee, and certainly Congress, understands it's not going to get any easier," said Dr. Cecil Wilson, board of trustees chairman for the American Medical Association.

The rising cost of health care is one of the biggest problems facing the government. At the current rate of growth, federal spending on Medicare and Medicaid will eventually consume 20% of the economy, according to Peter Orszag, Ph.D., director of the Congressional Budget Office.

"In health care, we get what we provide incentives for. We currently provide lots of incentives for advanced technologies and high-end treatment, and we get a lot of that. We provide very little incentive for preventive medicine and get very little of that," testified Dr. Orszag.

Early in 2006, lawmakers asked the Medicare Physician Advisory Commission (MedPAC) to examine ways to shift those incentives. Their findings were presented to the committee a few days before MedPAC members presented the commission's annual report to Congress.

Although the report represents the consensus of the commission, commissioners were unable to forge a consensus on what should be done to replace the Sustainable Growth Rate (SGR) system, MedPAC Chairman Glenn Hackbarth testified.

Instead, the commission offered lawmakers two alternative approaches—one that doesn't include an SGR-like spending target and one that does.

Eliminating spending targets altogether would require Congress to create a whole new system with incentives to physicians to provide high-quality and low-cost care, Mr. Hackbarth said. Choosing to keep spending targets would simplify payment reform but still would require changes to make the system more equitable.

In opposition to spending targets, Dr. Wilson said, "No amount of tinkering can fix what is broken beyond repair." While doctors account for a small portion of increasing premiums, they are the only group that has spending targets imposed on them, he added.

"The AMA asks that Congress ensure that physicians are treated like hospitals and other providers by repealing the SGR and enacting a payment system that provides updates that keep pace with increases in medical practice costs. We, in turn, are committed to helping assure appropriate use of services," he said.

In cooperation with several other physician groups, the AMA brought to the hearing a list of recommendations to achieve those goals.

No matter whose plan is embraced, fixing the SGR system is unlikely to come cheap. The CBO has estimated that current proposals will cost anywhere between $22 billion and $330 billion over 10 years.

"There are lots of steps, including [health information technology] and comparative effectiveness, that offer at least the potential to bend that curve over the long term, but the cost savings may not show up in the next 10 years. That is just the way it is," testified Dr. Orszag, adding that it will take time and resources to build a system in which Medicare pays for high-value instead of high-cost services. "Given the scale of the problems that we face, we need to be trying lots of different things and recalibrating all the time," he said.

There are good ideas out there, testified Mr. Hackbarth, but the Centers for Medicare and Medicaid Services is the bottleneck. "We've got some very promising demonstrations under way, but it takes us forever to get them developed, in place, gather results, and translate them into policy," he testified. The agency doesn't have the staff or information systems to move forward expeditiously.

"We're trying to run [Medicare] on the cheap. That won't work if we are trying to innovate at the same time," said Mr. Hackbarth.

Asked by senators what to focus on first, Dr. Wilson responded, "It would be nice if we had the luxury of just having one thing on our plate and one magic bullet, but we don't." ■

A Choice of Two Paths: Which One Leads to Better Care?

In testimony to the health subcommittee of the House Ways and Means Committee, Mr. Hackbarth explained that the MedPAC commissioners struggled with their task of choosing an alternative to the current sustainable growth rate (SGR) system. He reported that there were many tough debates, and that commissioners couldn't agree on just one solution. So instead they offered two proposals—ones they've deemed "Path 1" and "Path 2."

Path 1 calls for repealing SGR and eliminating the system of expenditures targets. The MedPAC report suggests that Congress should implement new ways to improve incentives for physicians and other providers to offer quality care to their patients at lower costs. This could be done in the following ways:

► Giving the Centers for Medicaid and Medicare Services the authority to pay providers differently based on performance measures;

► Ensuring accurate prices by identifying and correcting mispriced services;

► Encouraging coordination of care and use of care management, especially for patients with chronic conditions.

Path 1 also calls for collecting information on physicians' practice styles and sharing the results with other physicians across the country. If physicians could see how they use resources, compared with their peers, they would revise their practice styles accordingly, according to MedPAC's report.

The commission proposes that Medicare could then use the results to adjust payments to physicians and base rewards on both quality and efficiency.

Path 2 calls for pursuing the approaches in Path 1 but also including a new system of expenditure targets. The MedPAC report states that expenditure targets are necessary because they put "financial pressure on providers to change." It also recommends that targets should be applied on a geographic basis—applying the most pressure to the parts of the country where there is the highest use of the particular service and the highest contribution to Medicare spending.

Path 2, however, does goes on to propose that expenditure targets should not fall solely on physicians but rather be applied to all providers in an effort to encourage different providers to work together at keeping costs as low as possible.

—Glenda Fauntleroy