

PROFESSION**Stanford cuts liability premiums with cash offers after errors**

Quick investigations of adverse events followed by compensation for patients help save \$3.2 million annually.

By KEVIN B. O'REILLY, amednews staff. Posted Oct 31, 2011.

Stanford University's hospitals and clinics have saved \$3.2 million in annual premiums since establishing a program to disclose and investigate adverse events and offer an apology and compensation to patients when the bad outcome has been deemed preventable.

The results come on the heels of other successful experiments with a more transparent method of dealing with adverse events. The University of Michigan Health System, for example, says it has cut litigation costs by \$2 million a year and seen new claims fall by 40% with a similar disclosure, apology and compensation initiative.

Stanford's program was implemented in 2007 by the Stanford University Medical Indemnity & Trust Insurance Co., which covers the 1,800 faculty physicians at Stanford University School of Medicine, the 613-bed Stanford Hospital & Clinics and the 311-bed Lucile Packard Children's Hospital, all in Northern California. Claim frequency has dropped 36% compared with the two years before the program started.

"The board of directors was concerned about the possibility that this approach would really invite claims and make our costs go sky high," said Jeffrey F. Driver, chief risk officer at the Stanford insurance company. "We were monitoring the situation very carefully, and each half-year that we monitored we did not find that our claims were taking off."

As part of the Stanford program, the insurer investigates harmful adverse events reported by physicians, other staff or patients within 90 days of the bad outcome, so long as no legal action has been taken. Investigators try to assess within a week, through consultations with internal physician experts, whether the event could have been prevented. If investigators determine that the adverse event was avoidable, the family is contacted with the results, offered an apology and compensation is discussed.

Community physicians practicing at Stanford and covered by another medical liability insurer usually agree to the compensation offer, Driver said. "No one wants to be left holding the bag as the single defendant remaining," he added.

Stanford's results, verified by an independent actuary, were shared publicly for the first time in an Institute for Healthcare Improvement white paper released in October that offers guidance on how health care organizations should manage serious adverse events. A previous version of the paper was released in 2010 and has been downloaded more than 12,000 times and linked to by more than 6,000 websites.

Preparing for the worst

Hospitals, physician practices and other health care organizations should have a plan in place before bad things happen, according to the report, produced in collaboration with experts at many organizations that have pursued disclosure, apology and compensation programs. The 55-page paper gives advice on how to support affected patients, families, physicians and other health professionals, investigate adverse events, communicate internally and with the media, and offer apologies and compensation when appropriate.

The movement toward a more transparent and patient-centered method of responding to adverse events is picking up steam, said report co-author Jim Conway.

"People absolutely want to go there," said Conway, a senior fellow at the institute. "It's what they would want for their mother or father, and what they want for their patients."

Nonetheless, he said, many hospitals and other health care organizations are reluctant to share their experiences publicly for fear of alerting the plaintiffs' bar or drawing media scrutiny. Also, many organizations are using the disclosure, apology and compensation approach on a case-by-case basis and may not have formalized programs.

"We're still seeing organizations experiment in this space, and it's still going slower than we would like it to," Conway said.

ADDITIONAL INFORMATION:**WEBLINK**

"Respectful Management of Serious Clinical Adverse Events: Second Edition," Institute for Healthcare Improvement,

October (www.ihi.org/knowledge/Pages/IHIWhitePapers/RespectfulManagementSeriousClinicalIAEsWhitePaper.aspx)

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