

NIH Office Established to Improve Emergency Care

To help improve the health outcomes of patients who require emergency care, the National Institutes of Health (NIH) has created a new Office of Emergency Care Research (OECR). The formation of OECR is a result of more than five years of discussions between NIH and the emergency medical community, as well as a response to reports about the nation’s emergency medical system issued in 2006 by the Institute of Medicine. Serving as the focal point across NIH for basic, clinical, and translational emergency care research and training, OECR will foster and coordinate all such research and training in the emergency setting.

In announcing the new office, NIH Director Francis Collins said, “NIH has supported research to advance emergency care for years; however, now we have a single office to coordinate and foster our activities in this arena. The NIH Office of Emergency Care Research will focus on speeding diagnosis and improving care for the full spectrum of conditions that require emergency treatment.”

Although OECR will not provide funding for grants, it will encourage innovation and improvement in emergency care and in the training of future researchers in the field by:

- Coordinating funding opportunities that involve multiple NIH institutes and centers;
- Working closely with the NIH Emergency Care Research Working Group, which includes representatives from NIH institutes and centers;
- Organizing scientific meetings to identify new research and training opportunities in the emergency setting;
- Catalyzing the development of new funding opportunities;
- Informing investigators about funding opportunities in their areas of interest;
- Fostering career development for trainees in emergency care research; and
- Representing NIH in government-wide efforts to improve the nation’s emergency care system.

While a search is being conducted for a permanent director of OECR, Walter Koroshetz, deputy director of the National Institute of Neurological Disorders and Stroke, is serving as acting director. A steering committee chaired by the director of the National Institute of General Medical Sciences, where OECR is housed, is overseeing the office.

For more information about this new NIH Office, visit <http://www.nigms.nih.gov/About/Overview/OECR>.

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MA Enacts Prescription Drug Abuse Law

On August 18, **Massachusetts** Governor Deval Patrick (D) signed into law a bill intended to crack down on prescription drug abuse and more closely monitor the way prescriptions are dispensed in the state. At an impasse for more than six months, the bill sponsored by Senator John Keenan (D-Quincy) finally began advancing in the House during the last weeks of the Legislature's sessions, and the version of the bill ultimately agreed to by both branches was sent to Patrick on August 9.

Under the new law, participation in the state's prescription monitoring program by doctors who prescribe controlled substances becomes mandatory, rather than voluntary. And, to eliminate what some doctors described as a "cumbersome process" of paper applications, doctors will be automatically enrolled in the program when they renew their medical license. This automatic enrollment provision addressed a concern expressed by the **Massachusetts** Medical Society about low levels of involvement with the program (currently, only 1,800 prescribers out of nearly 40,000 in the state are registered for the program).

In addition, the law requires that patients enrolled in MassHealth (the state's Medicaid and CHIP program) who fill 11 prescriptions from four doctors or at four different pharmacies within 90 days be put on a watch list. The law also includes a ban on the designer drug known as "bath salts," giving police the tools needed to fight this new and dangerous group of drugs sold legally over the counter in head shops and some convenience stores, as well as on the internet.

The law places strict regulations on doctors and pharmacists when handling prescriptions for controlled substances. It prohibits pharmacies from filling prescriptions for narcotics unless written by a doctor licensed and registered in-state, or in one of the five contiguous states to **Massachusetts** and Maine. It also requires that prescriptions for controlled substances be written by doctors on "secure," tamper-proof prescriptions pads (already required for Medicare and Medicaid patients), and that pharmacies and registered drug manufacturers, dispensers, or distributors report losses or

thefts of controlled substances to the federal Drug Enforcement Agency, as well as to local and state police departments. While the law still requires that pharmacies sell drug lockboxes, they will only have to advertise them near registers. Finally, the law calls for the Department of Public Health to provide patient information on the dangers of Class II and Class III drug, and that a working group of physicians be tapped to write a "best practices" guide for prescribing opioids.

At the signing, Patrick said that he strongly supports the bill. But, he also raised concerns over the resources appropriated for the state's Department of Public Health to put provisions of the new law into place.

Massachusetts ED Costs Increase Dramatically

A new report finds that unnecessary ED costs in **Massachusetts** have gone up by about 35%, or nearly \$150 million between FY 2006 and 2010. The Division of Health Care Finance and Policy report found there were nearly 2.5 million EDs in FY 2010, and about half those visits were preventable or avoidable.

State lawmakers say that they expect the costs to go down in the future. The Senate's Health Care Financing Committee Chairman, Richard Moore, says the state's new health care law will promote access to primary care doctors and reduce emergency department visits in the future.

Despite costs going up, the report found that the number of ED visits is going down. It also recommends that there should be a greater availability of healthcare services to reduce unnecessary costs.

Missouri Court Overturns Cap on Non-Economic Damages

On July 31, the **Missouri** Supreme Court struck down the state's cap on the non-economic damages that can be awarded by a jury in a medical malpractice case. In the case before the court – *Watts v. Cox Medical Center* – a woman whose son was born with severe brain injuries sued the Springfield hospital and its medical clinic, alleging negligence. A jury awarded the mother,

Deborah Watts, \$3.37 million for past and future medical damages, \$1.45 million for pain and suffering. The pain-and-suffering award was later reduced to \$350,000 because that was the most allowed by Missouri law.

In its 4-3 decision, the **Missouri** Supreme Court ruled that the state's cap on non-economic damages violated Watt's right to a jury trial and was thus unconstitutional. In part, the ruling read: "Statutory damage caps were not permissible when the (Missouri) constitution was adopted in 1820 and, therefore, remain impermissible. The right to trial by jury cannot 'remain inviolate' when an injured party is deprived of the jury's constitutionally assigned role of determining damages according to the particular facts of the case." The ruling was limited to jury awards in medical malpractice cases.

The **Missouri** State Medical Association (MSMA) condemned the decision, accusing the court of eviscerating "one of the nation's most successful tort reform laws," a reference to the \$350,000 cap on pain and suffering. According to MSMA, the cap had allowed the state to stabilize its once-erratic insurance market which, in turn, drew more physicians to Missouri and improved access to care. The association urged the state's governor and General Assembly to "make restoration of the cap their highest legislative priority in 2013."

Oregon Workgroup Drafting Tort Reform Legislation Considers Disclosure

When the **Oregon** Legislature convenes next February, lawmakers are expected to take up tort reform. To get those discussions moving, a Patient Safety and Defensive Medicine Workgroup is developing draft legislation that includes issues such as confidentiality, mediation, dispute resolution, litigation, discovery, and patient safety. Also on the table is disclosure, i.e., informing patients when a serious medical event has occurred in a hospital setting.

Robert Dannenhoffer, a Roseburg pediatrician, told the workgroup that such a disclosure approach has been successful at Mercy Medical Center. Dannenhoffer, who is also CEO of the coordinated care organization

Umpqua Health Alliance, explained that all medical staff and employees of Mercy Medical Center have participated since 2001, and are required to disclose serious events in a non-punitive hospital reporting system, while the hospital works in good faith with families to make them "whole." Patients, he said, are not necessarily looking for money, but want their losses covered and want to make certain the same mistakes do not occur again.

Richard Boothman, a former trial attorney, reported to the workgroup on a disclosure program under way at the University of Michigan Health System since 2001. Its quality and safety division is closely tied to the disclosure program, with money invested in improving patient safety, Boothman said. As a result, medical malpractice claims have decreased from 53 to 31 per year, while the average cost per lawsuit has dropped from more than \$400,000 to around \$228,000, and the time to resolution has decreased from 20 to eight months. Physicians are very satisfied with the program, with 98% of 419 surveyed indicating their approval. Approximately 86% of plaintiff's lawyers also approve, saying the transparency allows them to make better decisions about which claims to pursue.

In conclusion, Boothman said, "The long-term benefits are clear to us. We've seen some remarkable things happen." He added that, in July 2001, the number of pending claims involving the system totaled 262. Now, that number is down to 64, with only 10 claims ending up in court last year, despite the fact that clinical activity has doubled since then, and twice as many patients are receiving care. He cautioned, however, that many people are invested in the status quo, including judges and defense attorneys.

Robin Moody, of the **Oregon** Association of Hospitals and Health Systems, told the workgroup that most **Oregon** hospitals currently offer early disclosure. But Moody also said she was "disappointed" that the section of the group's draft bill dealing with litigation was so short. Even in a "model" system like Michigan's, she said, several cases still end up in litigation.