



Protecting Providers.
Promoting Safety.

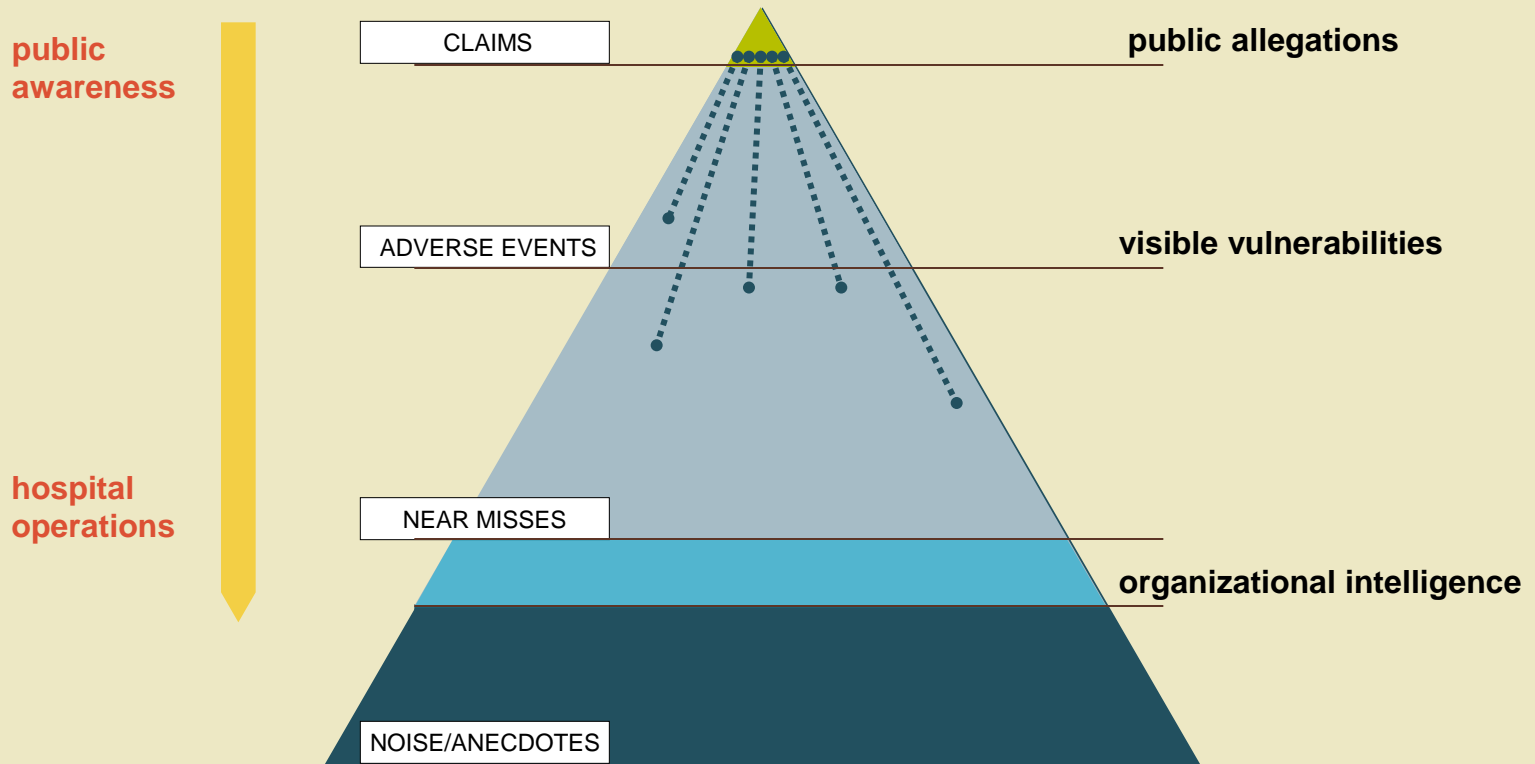
Signal Detection:

How the study of malpractice claims can drive fundamental change

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Claims are the tip of the iceberg...



The Model Methodology: Data into Action

Capture vulnerabilities as they occur

- Contemporaneous analysis of asserted malpractice cases

Put them into context

- Integration of relevant denominator data and peer comparative data

Are you still vulnerable?

- Assessment of present-tense risk through *risk assessments, focus groups, and through validation by other data sets*

Determine potential solutions

- Continuous identification of relevant models, processes, education, and training programs that address key risk areas

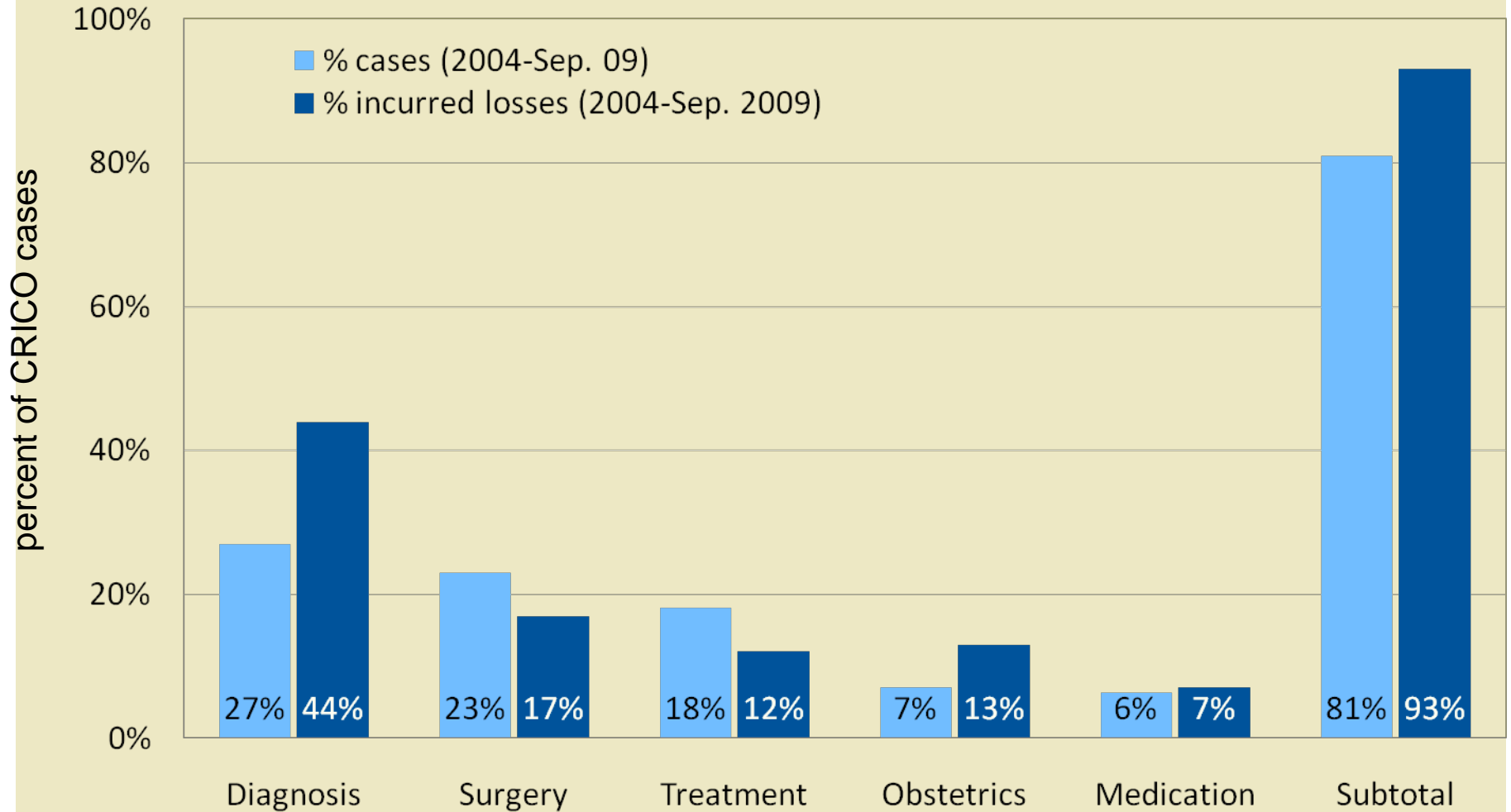
Implement, educate, train: *the “reinvestment”*

- Championship by high-level leadership to effect real change and to sustain it; *leverage by insurer to accelerate movement*

Measure/Metrics

- Measure the impact in the near term (with a predictive eye for the long term)

CRICO Target Areas: Key Areas of Risk



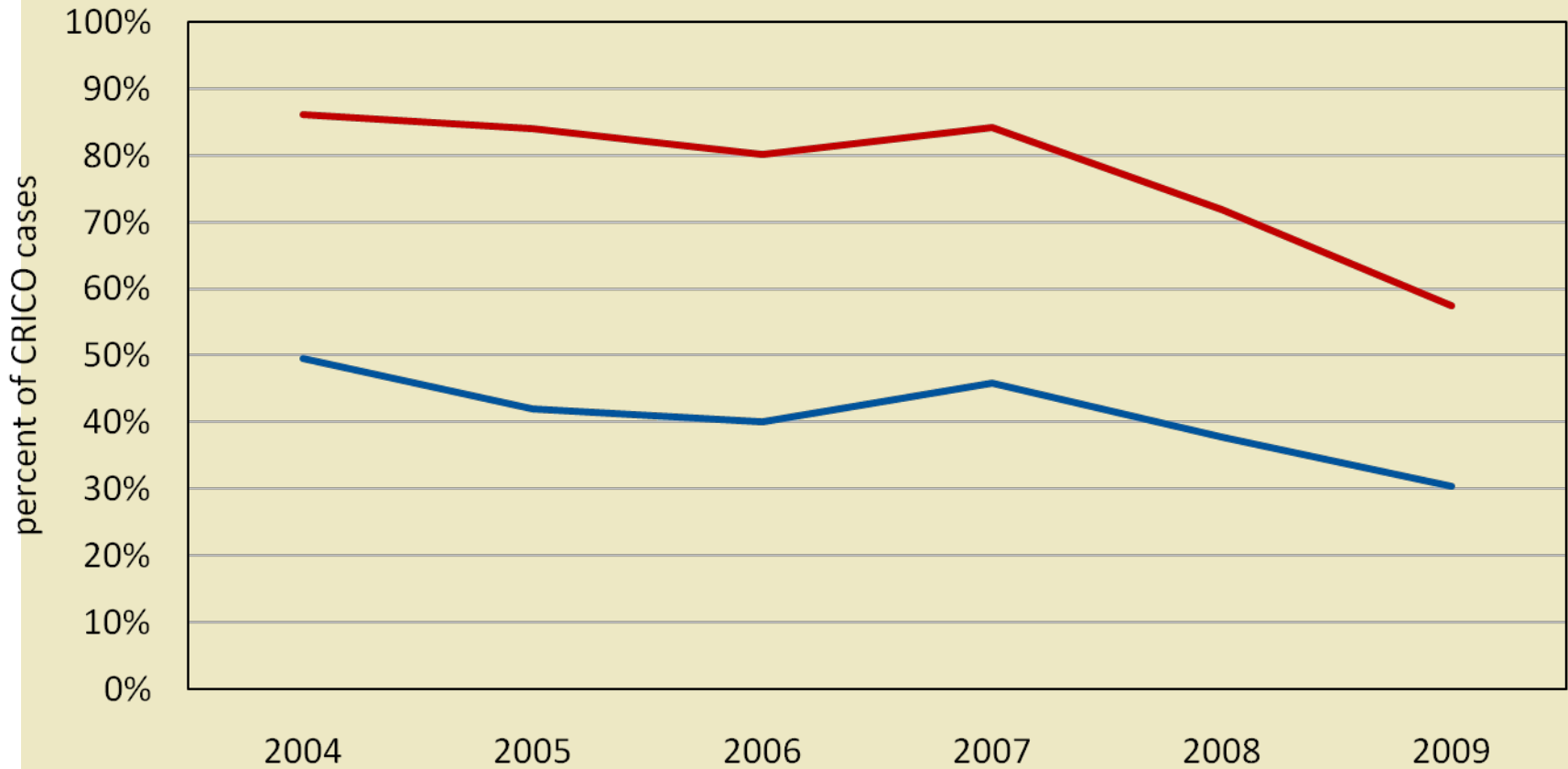
N = 1,260 CRICO PL cases asserted 1/1/04-9/30/09 with total incurred losses of \$614 M.

crico

Trend in High-severity Cases

High-severity cases as a percent of all cases asserted

— % of total incurred — % of cases



N=1,299 CRICO PL cases asserted 1/1/04-11/30/09, 534 cases with a high severity injury.

How Our Analysis Works....

Several cases alleging negligence in performing laparoscopic surgery

- *Were they significant?*
- *What did they mean?*
- *How to respond?*

Treated the small data set as an important signal

*Was the problem validated? ... **YES***

Now: *need to sustain the consistent training*

Dove Deeper:

- Were the complications avoidable?
- What training did the surgeons have?
- Was the training consistent?
- Was training required?

Acted:

- Designed an intervention
- Measure baseline
- Implemented intervention: Fundamentals of Lap. Surgery for all general surgeons (with modest premium incentive)
- Measure impact

Monitor:

- Develop credentialing/privileging criteria with Gen. Surgery departments to ensure durability

The Model Methodology: Building an Inventory of Solutions



Prevention of Diagnostic Errors

- **Reliable office-based systems or processes that support—**
 - **Routine updating of family history**
 - **Receipt of test results** by ordering providers (including critical test results)
 - **Tracking/managing follow-up steps related to pt.’s subsequent care**
 - **“Close-the-loop” management/accountability of specialty referrals**
 - **Communication of *all test results* to patients**, including routine chest x-rays (“incidental findings”)
- Ongoing, interval-based education of clinicians to **avoid fixation, narrow diagnostic focus**
- **Decision-support guidelines/algorithms embedded into I.T. system** so providers can access them in the flow of patient care

Prevention of Surgical Errors and Poor Patient Outcomes

- Robust **informed consent protocols** being used consistently in pre-op phase
 - Use of **web-based patient education materials** to supplement informed consent discussion
- Hard-wired processes for **checking accuracy of surgical sites** (with built-in safety nets)
- **Bar-coded sponge technology** or **radiofrequency technology** to eliminate retained foreign body events
- **Simulation-based skills training center and program** that requires residents, fellows, and attending surgeons to practice their skills and/or develop new surgical skills
- **Communication triggers**, residents to attendings
- Communication protocols for **handoffs** between shifts, transitions of pts from OR to recovery
- Implementation of the **Surgical Safety Checklist** (for the pre-op, intra-op, and post-op phases of surgical care)

Prevention of Obstetrical Injuries

- **Decision support guidelines** accessed by all obstetrical providers
 - **Decision support embedded into electronic medical record**
- OB unit staff has **undergone team training**; refresher courses are sustaining the team-based culture
- OB unit periodically receives **simulation training** to practice **crisis response, technical, and cognitive skills**
- OB unit conducts unit-based **shoulder dystocia drills**
- Coverage model that ensures that **OB attendings** and other **necessary clinical** are present in unit 24/7
- Required, consistent **Electronic Fetal Monitoring (EFM) training** for all clinicians in OB unit

Prevention of Medication Error

- I.T.-based safeguards in place for Pharmacy to detect and modify **MD prescribing errors**
- I.T.-based safeguards to ensure that **Pharmacy** identifies and remedies **medication-mixing errors**
 - Specific safeguards for **neonatal and pediatric medications**
- Safeguards in place to ensure that **RNs are not making medication administration errors**; possible use of bar Coding technology
- Active **medication reconciliation program** in place throughout organization (admission and discharge)
- **Computerized Physician Order Entry (CPOE) and E-Prescribing solutions**
- I.T.-based safeguards for ongoing **monitoring of patients on long term medications**

Prevention of Emergency Dept Risk

- Resources in place so that **discharged ED patients are routinely contacted re any test results pending at time of their discharge**
- I.T. system that allows all providers to **share same understanding of the status of ED patients and to act in concert with each other**
- Crisis-response and cognitive **simulation training** readily available to all ED residents, nurses, and attendings
- **Team-trained environment**
- An **ED patient-border policy** that clearly defines accountability of ED borders and allows for the ED to move admitted patients out of the ED when specific volume thresholds are exceeded

Patient Safety Organization (PSO)

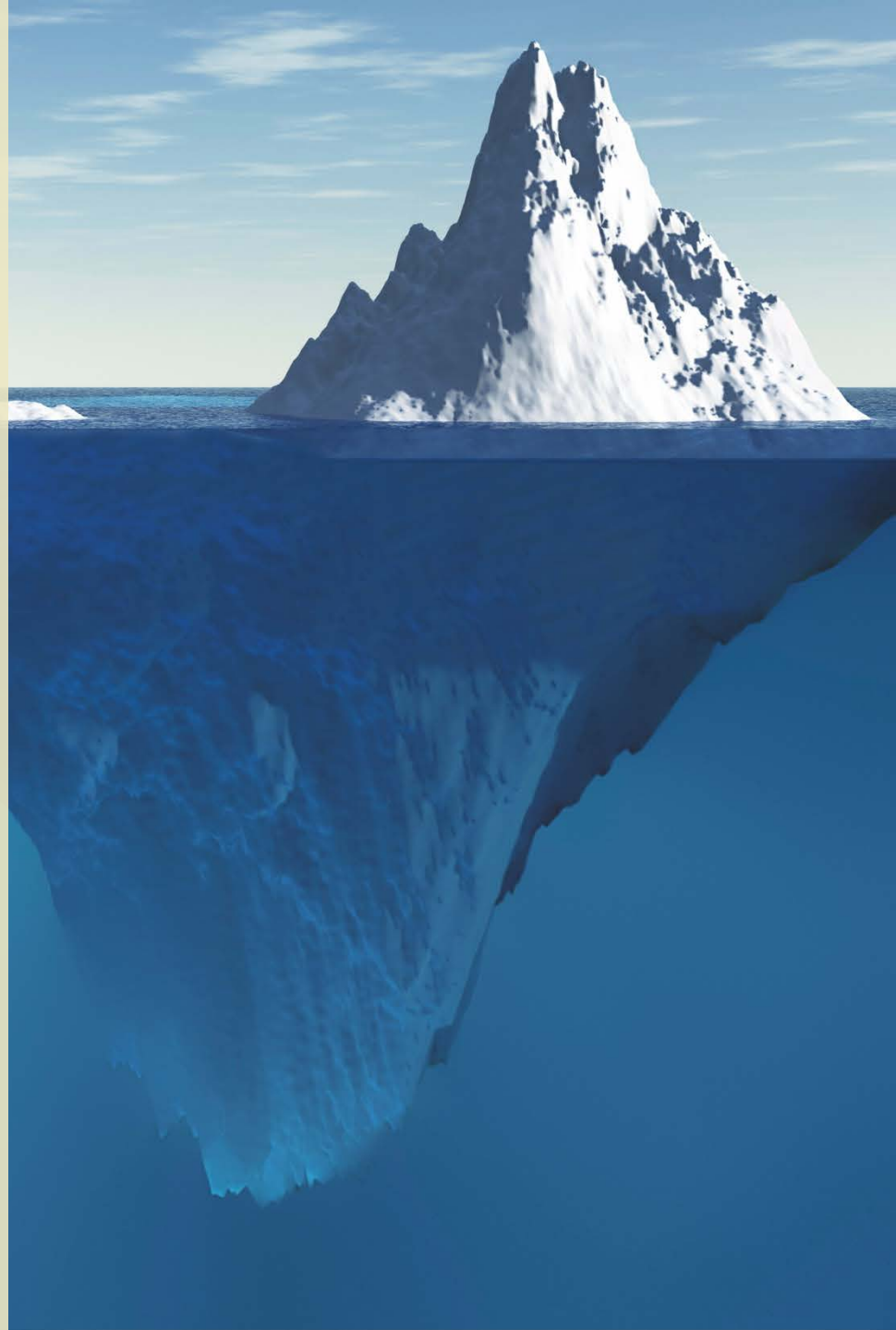
- Established by the Patient Safety and Quality Improvement Act of 2005
- Voluntary sharing of information related to safety and quality under a federal grant of confidentiality and privilege



The PSO Vision

A PSO structure can harness risk data and transform it into safer patient care.

- An evolution to the next stage of patient safety research, insight, and application:
- carve a path through excess data “noise”
- bridge disparate data sets to present a clearer view of health care delivery failures
- move health care entities and providers to engage in the most important discussions—and implement the most needed interventions



Building the safest healthcare system in the world

Current State
 Gap between present and desired state



Desired State
 Maximum reduction of medical error and financial loss

Diagnose the problems Explore of TX Options Implement/Measure

Organizational	Clinical		
Risk Assessment	CRIT	CRIS	PSO
Assessment of Patient Safety Profile: ability to manage risk	Analytical Tools: Individual and Comparative Data	Analysis, consultation recommendations education	Peer-protected community for discussion of real-time vulnerabilities, solution options, implementation strategies, and metrics

Clinical Coding

Weak signals Moderate signals Strong signals