
The

Risk Retention Reporter

Evidence-Based Risk Management Leads to Lower Rates and Claims for Medmal Risk Retention Group

*A Risk Retention Reporter interview with Jack McCarthy, President of the
Risk Management Foundation of the Harvard Medical Institutions
the administrative organization for
Controlled Risk Insurance Co. of Vermont (A Risk Retention Group)*

RRR: *It would seem from the very name of your organization, i.e. the Risk Management Foundation of the Harvard Medical Institutions — that risk management has always been integral part of your mission.*

McCarthy: True. We believe that effective risk management is fundamental to our success as an RRG and that evidence-based risk management provides the proven, workable method to achieve our goals.

RRR: *Put simply, what is “evidence-based risk management”?*

McCarthy: Evidence means just what it says — carefully gleaned data analyzed and arrayed in an actionable form. This data is then used to target risk management and loss prevention efforts. These efforts range from developing educational programs to creating standards of care and guidelines for loss avoidance. The “evidence” is grounded in the claims experience of the RRG coupled with any related information such as incident reports, physician office practice assessments, patient satisfaction data, and best practices.

RRR: *What does it take to generate this information within your organization?*

McCarthy: We insure 8,500 physicians, 23 hospitals, and 400 subsidiary organizations for professional liability, general liability, and association liability. Our staff manages claims from start to finish, working closely with outside law firms. The data is generated from several sources. Underwriting provides information about physician specialty, practice setting, and claims history. Claims staff provides insight into what is actually happening within the claim, including theories of liability. The loss prevention staff and a single coding analyst describe the claim in narrative

form and code the claim for clinical and risk management issues. This coding process is dynamic and incorporates a broad range of sources. As we compile clinical reviews of each case, the codes are continually updated to be as accurate as possible. When the claim is closed, it goes through one final review by claims staff.

The result of these efforts is a heavily coded database of claims information, which integrates a great deal of insight into what went wrong. Analytical tools are then used by the Loss Prevention Specialists and Risk Managers to determine trends and opportunities for improvement.

RRR: *Why are RRGs in a unique position to generate this information?*

McCarthy: An RRG has the ability to either control its claims directly or to require vendors to provide sufficient information to code their claims. This is a far cry from simply paying a premium to an insurance company and hoping to get some reports concerning claims activity. The RRG has a clear incentive to compile and use this data effectively to reduce loss exposures.

RRR: *How does “Evidence Based Risk Management” enhance your risk reduction efforts?*

McCarthy: Our database and analysis allow us to be very specific about where and why losses are occurring. The ability to sit down with a risk manager or physician leader or practice manager and show their claims trend versus the rest of the program, with their actual losses coded to reflect the clinical and risk management issues, makes for a very rich discussion.

In addition, knowing where claims are emerging allows us to intervene earlier to stem losses and to put preventative measures into place.

RRR: Do you need elaborate systems to generate this information?

McCarthy: No. Much of the data already exists in many risk management information systems. We add clinical information using a comprehensive coding scheme and analytical software to array the data. Since one question often leads to another and another and another, the more comprehensive your database and the more powerful your ability to array the data, the greater the flexibility you have in manipulating (in a good sense) the data. We look at many dimensions, physician specialty, sponsoring institution, allegations, injury, severity, groupings of risk management issues, and procedure codes. The challenge is not to just produce data, but to surface “actionable data,” and then to act on what that data is telling you.

RRR: Do physicians and staff understand how to use this data?

McCarthy: It’s quite a shock to newly insured hospitals and physician groups to see their experience arrayed against the rest of their specialty or peer group. We are also developing a national database containing consistently coded claims information to add weight to this information. When confronted with accurate data, physicians and institutions respond quite well. We often use the data as a starting point for improvement efforts. Using the data in a positive, non-punitive way is also important. The data supports a great deal of our educational initiatives and other services. Remember, physicians are scientists and they are competitive. Once you show them the “evidence,” they don’t want to be outliers. They want to be the best!

RRR: What is an example of how this “actionable data” is used to make improvements?

McCarthy: In the early part of 1999, we noticed a marked increase in the number of failure to diagnose breast cancer claims. In fact, during the first three months of 1999, we had received as many claims as we had received during the entire preceding year. At the same time, the valuation of these cases had almost doubled to \$1.2 million per claim.

Our response was to assemble the data from the previous five years. Based on our coding structure we were able to determine the primary drivers of these claims. These drivers included patient management, lack of follow-up on significant findings, failure to re-evaluate patients with questionable findings, and poor referral controls.

We then assembled a group of clinicians including radiologists, OB/GYN physicians, and mammographers. We reviewed the data and related claims. The result was creation of a breast care algorithm and a great deal of education on how to provide safer care to this category of patient. The algorithm is on our web site at <www.rmf.harvard.edu>. The claims experience has exhibited a significant decline post-1999.

We are now engaged in a similar effort concerning failure to diagnose colo-rectal cancers.

RRR: We have heard a lot about patient safety. What is that all about?

McCarthy: The interest in patient safety was spurred by an Institute of Medicine report “First Do No Harm” detailing the high error rates in healthcare settings and alluding to the number of unnecessary patient deaths. To say that this report has galvanized efforts to improve safety of care would be a gross understatement. Healthcare providers have begun to address

issues like medication safety and automated drug order entry with a great deal of energy. A dialogue concerning systems has also developed. It is now recognized that poorly designed systems often are the primary contributor to errors being made. Latent system errors increase the likelihood of people errors. Patient safety embodies a call to action in addressing avoidable systems errors.

RRR: How does “evidence” relate to patient safety?

McCarthy: Malpractice claims have long been used as examples of well documented systems errors. These claims or evidence, when combined with trended data, make a compelling argument for systems improvement. It is our belief that attention to systems of care will yield significant improvement in patient safety and will ultimately reduce the likelihood of malpractice claims.

RRR: How would you target these efforts?

McCarthy: Once again, we go back to the data. Our claims experience, analyzed over a ten-year period, indicates that there are four main areas of loss accounting for 67% of our claims and 91% of our loss experience. The four are:

- Failure to Diagnose
- Medication Error
- Surgical Error
- Obstetrical Error

We are building business plans around each of these target areas. The approach includes on-line educational programs, incident reporting, and human factors engineering. Several hospitals are installing computerized drug order entry systems to reduce medication errors. A team from MIT is conducting a human factors engineering study of a major surgical department. Beta sites for a computerized medical error reporting system are coming on-line. All of these efforts were the result of concern over patient safety and the use of data to target for high payback interventions.

Jack McCarthy is President of the Risk Management Foundation of the Harvard Medical Institutions. This organization consists of a Vermont Risk Retention Group and a Cayman Captive. It insures 8,500 physicians, 23 hospitals, 110,000 employees and over 300 subsidiary organizations. Liability coverage includes policies for professional, general, association, environmental and intellectual property exposures.

The Risk Management Foundation is the administrative organization for the RRG. RMF is located in Cambridge, Massachusetts. Its 110 employees manage claims and provide loss prevention services to the sponsoring organizations.

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