Glossary

Terms Used in CRICO's Comparative Benchmarking Data Analyses

ALLEGATION

Allegations are the claimant's perspective on what transpired. Many allegations can be coded for a claim, but only one is chosen as the Major Allegation.

Examples:

Anesthesia allegations pertain to the choice of anesthetic, the administration of the anesthesia, and proper positioning of the patient.

- Improper anesthesia administration—e.g., patient alleges she awoke during surgery and felt the pain of the operation; the anesthesia canister was empty for 10 minutes before a new one was attached.
- Improper positioning—e.g., morbidly obese patient experienced pain and neuropathy in right arm following surgery. Allegation states that an extra wide table should have been used during surgery to accommodate patient's body.
- Anesthesia related—other—e.g., patient suffered damage to teeth when extubated.

Medical Treatment allegations refer to procedures and/or treatment regimens that are non-surgical in nature and most frequently occur at the bedside or in procedure-based locations. Some examples include the placement of arterial or central lines, including shunt placement for hemodialysis patients, lumbar punctures, chest tube placement, cardiac catheterizations, angioplasties, endoscopies, and colonoscopies. Other treatment related cases involve the use or lack of use of chemotherapy, radiation, physical or occupational therapy, or other treatment regimens that are either delayed, not performed, or are provided, but go awry.

Obstetrics-related allegations are primarily about choice and timing of the delivery and the recognition of fetal distress, but also include management of the pregnancy.

- Improper choice of delivery method—e.g., cesarean delivery should have been performed due to signs of pre-eclampsia and fetal distress.
- Improper performance of vaginal delivery—e.g., infant suffered shoulder dystocia and Erb's palsy; tight shoulders noted, but no special maneuvers performed or forceps used.
- Delay in treatment of fetal distress—e.g., fetal distress noted, but labor continued for 3½ hours; baby born with deficits.

Surgical allegations include technical performance issues, delays in surgery, retained foreign bodies, and unnecessary surgery.

- Improper performance of surgery—e.g., surgeon prepped and made initial incision on wrong side for hernia repair.
- Improper management of surgical patient—e.g., breast prosthesis removed due to post-operative infection; patient should have been discharged with antibiotics following surgery.
- Retained foreign body—e.g., child treated in ED for cut foot; eight months later, X-ray revealed glass in foot.

CASE RATE

CBS provides eight types of case rates: PCY, (physician coverage years), births, emergency department visits, outpatient visits, inpatient days, total surgeries, inpatient surgeries, and outpatient surgeries. Case rate allows users to compare between small and large hospitals and to examine trends in the data over time.

- "Case rate" is equal to "case count" divided by "exposures" then multiplied by a "multiplier." (case count/exposures)×multiplier
- Claim count (numerator) is much smaller than exposures (denominator) so CBS uses a "multiplier" to avoid a case rate with more than three decimal points. The multiplier will vary for different case rates. For example, Hospital A's birth case rate is its obstetrics-related cases divided by its total births delivered then multiplied by a "multiplier" of 1,000.
- CBS automatically selects corresponding cases (numerator) and multipliers based on users' selection of a denominator.

CLAIM

An actual complaint and claim for damages has been made by either the claimant, claimant's family, or an attorney. Reserves are established and an investigation is conducted.

CONTRIBUTING FACTORS

- Contributing Factors cover a broad spectrum of circumstances that may have contributed to allegations, injuries, or the initiation of a claim. Contributing factors allow identification of common areas of concern across different services and settings and are amenable to risk management and reduction strategies.
- Many contributing factors may be coded on a single case.
- There are more than 170 contributing factors organized into a three-tiered scheme. The three tiers allow for progressively more detailed reporting.

For example:

TIER		EXAMPLE
1.	Category:	Clinical Judgment
2.	Sub category:	Patient Assessment
3.	Detail:	▪ Narrow diagnostic focus of atypical presentation ▪ Lack of/inadequate patient assessment - failure to note clinical info ▪ Misinterpretation of diagnostic results, etc.

INPATIENT DAYS

The total number of days spent in overnight increments in an acute care setting. Count does not include Skilled Nursing (SNF) and Rehab days even if in the same acute care facility. Inpatient days include:

- Acute Days
- ICU Days
- Maternity Days
- NICU Days
- Nursery Days
- Psychiatric Days

OUTPATIENT VISITS

Total number of visits occurring in an outpatient office, hospital or clinic setting including all diagnostic, therapeutic, and procedural activities not otherwise classified as "surgical." Count is relevant to number of "patient visits" not number of "procedures" (e.g., specimens sent in from MD office / OR). Outpatient visits include:

- Routine and specialty visits in a physician office setting by a MD/ NP/ PA
- Outpatient diagnostic visits are as follows:
  - Ambulatory Care: non-surgical diagnostic procedures (e.g.., endoscopy, colonoscopy)
  - Cardiac: stress testing, etc.
  - Laboratory: blood, cultures, specimens
  - Pulmonary: incentive spirometry
  - Radiology: diagnostic and therapeutic radiology
- Outpatient treatment visits to pain clinic, oncology, rehabilitation, and PT / OT /ST

RESPONSIBLE SERVICE

- The responsible service is coded as the clinical service most responsible for the patient at the time of the event. Secondary services may also be captured, but only one will be listed as Primary.
- Medical subspecialties (e.g., cardiology, dermatology, endocrine, gastroenterology, hospitalist, neurology) and surgical subspecialties (e.g., colorectal surgery, cardiac surgery, hand surgery, pediatric surgery, urology surgery) are grouped into categories to enable better reporting.

SEVERITY

A severity rating of the outcome of the claimant's injuries allegedly caused by the event, derived from the National Association of Insurance Commissioners (NAIC) Severity scale 0-9:

High (6-9)—Death, Permanent Grave, Permanent Major, or Permanent Significant. Injuries include loss of limb, loss of kidney or lung, paraplegia, quadriplegia, severe brain damage, fatal prognosis.

Medium (3-5)—Permanent Minor, Temporary Major, or Temporary Minor. Injuries include infections, fractures, delayed recovery, burns, retained surgical materials, drug side effects, loss of fingers, and damage to organs.

Low (0-2)—Temporary Insignificant, Emotional Only, or Legal Issue Only. Injuries include lacerations, contusions, minor scars, and rash. Legal issues include lost medical records, property damage, depositions.

SUIT

Legal documents have been filed in court claiming damages as a result of an event. Reserves are established, a defense attorney is assigned, and an investigation is conducted.