Validate Your Malpractice Risk
The Westin San Diego | November 10-11, 2011

Co-sponsored by:
The Doctors’ Company Foundation and CRICO Strategies
Today's Objectives:

Explore and discuss the use of data for signal detection

Validate what the data are telling us

Review proven interventions in light of a validated data set

“Hazard Detection” as the path forward

Leave with tactic and intervention ideas

Today's Agenda

- Overview
  - Setting the Stage

- The Need for a Process

- Model Methodology
  - Framing and Key Findings

- Data Review
  - Claims Analysis and Findings

- Validation Workshops

- Summary and Recommendations
  - Themes and Specific Issues
  - Lessons Learned
  - Closing Remarks
Using Data to Understand the Risk and Help Prevent Malpractice Claims

Richard E. Anderson, MD
Chairman and Chief Executive Officer
November 11, 2011
Introduction

• We are proud to partner with CRICO to present this symposium
• A few words about TDC and our mission
• We are pleased you are here and we hope to learn from your experiences as well as discuss our own
• Malpractice litigation is far too common in our society
• The process is repugnant and destructive to virtually all physicians
RAND: Proportion of Physicians Facing a Malpractice Claim Annually

Today

• We want to show you how we capture and analyze data
• We would like to demonstrate how those data can be used to implement risk reduction strategies with a goal shared by all: Improve patient outcomes
• We would like you to see how this can be done within the unique context of your own practices
OB Neonatal Claims with Indemnity >$100,000

- Manually assisted delivery (33%)
- No procedure associated with injury (30%)
- Vacuum extraction (19%)
- Cesarean-section (11%)
- Forceps delivery (6%)
Emergency Medicine Allegations

Allegations

- Failure to diagnose (54%)
- Improper management of treatment course (9%)
- Delay in diagnosis (7%)
- Improper performance of treatment or procedure (6%)
- Delay in treatment or procedure (3%)
ER: Failure to Diagnose What?

Top 8 Final Diagnoses Related to Allegation "Failure to Diagnose"

- Complications of pregnancy: 1.9%
- Torsion of testes: 2.2%
- Pneumonia: 2.7%
- All forms of meningitis: 2.7%
- Aortic aneurysm, arterial embolism: 3.0%
- Acute appendicitis, obstruction, peritonitis: 7.0%
- Intracerebral hemorrhage, CVA, aneurysm: 8.0%
- Acute MI and other cardiac disease: 14.1%
Assumptions

Do you know what you know...do you know what you don’t know....
...is what you know all you need to know?

Richard Corder
Assistant Vice President, CRICO Strategies
• **Assumption** an action or belief based on a limited set of data

• Assumptions about what we see based on our perception

• Assumptions about what we see based on our perception, our emotional bias, and often in the absence of additional facts

• **Assumptions** are sometimes necessary and all we have…
Video – English detective - whodunit

http://www.youtube.com/watch_popup?v=ubNF9QNEQLA&vq=medium
On assumptions...

“The temptation to form premature theories upon insufficient data is the bane of our profession.”

Sir Arthur Conan Doyle
Comparative Benchmarking Data
What signals do the data suggest?
14,790 cases | 2006 - 2010
$3B total incurred
National Malpractice Landscape: **Responsible Service**

What services are top drivers of claims and dollars?

N=14,790 coded PL cases asserted 1/1/06–12/31/10.

*Other includes Allied Health, Non-Clinical, and Pharmacy.

Total Incurred= reserves on open and payments on closed cases.
National Malpractice Landscape: Top Major Allegations

Allegations cluster similar “case types” - may cut across Responsible Services

Resp. Service: Surgery

Resp. Service: Medicine

Resp. Service: Nursing

N=14,790 coded PL cases asserted 1/1/06–12/31/10.
National Malpractice Landscape: Five-year Trends
Trends by Key Major Allegations

Where have we made the greatest impact?

N=14,790 coded PL cases asserted 1/1/06–12/31/10. 12,061 cases with a Diagnosis, Surgical TX, Medical TX, Obstetrical TX, or Medication major allegation.
Individual organizations vary from the national landscape

National Malpractice Landscape: **Top Major Allegations**

- **Surgical Tx**: 4,500 cases
- **Medical Tx**: 3,500 cases
- **Diagnosis**: 3,000 cases
- **Medication**: 2,500 cases
- **Safety & Security**: 2,000 cases
- **OB-related Tx**: 1,500 cases
- **Anesthesia**: 1,000 cases
- **Patient Monitoring**: 500 cases

N=14,790 coded PL cases asserted 1/1/06–12/31/10.
For CRICO, diagnostic claims are now the top allegation

CRICO: Top Major Allegations

N=1,145 CRICO PL cases asserted 1/1/06–12/31/10.
Total Incurred= reserves on open and payments on closed cases.
Where in the course of care are errors most prevalent in outpatient diagnosis-related cases?

National Landscape — Diagnostic Process of Care

<table>
<thead>
<tr>
<th>STEP</th>
<th>Number of Cases</th>
<th>Percent of Cases</th>
<th>Total Incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>31</td>
<td>2%</td>
<td>$9,955,779</td>
</tr>
<tr>
<td>2.</td>
<td>472</td>
<td>28%</td>
<td>$199,150,361</td>
</tr>
<tr>
<td>3.</td>
<td>875</td>
<td>52%</td>
<td>$330,620,819</td>
</tr>
<tr>
<td>4.</td>
<td>55</td>
<td>3%</td>
<td>$15,939,947</td>
</tr>
<tr>
<td>5.</td>
<td>559</td>
<td>33%</td>
<td>$227,643,843</td>
</tr>
<tr>
<td>6.</td>
<td>153</td>
<td>9%</td>
<td>$55,923,284</td>
</tr>
<tr>
<td>7.</td>
<td>220</td>
<td>13%</td>
<td>$97,347,143</td>
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<td>8.</td>
<td>370</td>
<td>22%</td>
<td>$127,040,180</td>
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<tr>
<td>9.</td>
<td>222</td>
<td>13%</td>
<td>$46,071,957</td>
</tr>
</tbody>
</table>

1,699 cases | $495M total incurred

Process of Care

Clusters causative factors into steps of care from access issues in seeking care, to reporting test results and appropriate follow up including referrals.

*A case will often have multiple factors identified.

N=1,699 coded PL cases asserted 1/1/06–12/31/10 involving outpatients (excluding ED location) and with a diagnosis-related major allegation.

Total Incurred=reserves on open and payments on closed cases.
What are the most prevalent contributing factors in obstetrical cases?

National Landscape — Top Contributing Factors

<table>
<thead>
<tr>
<th>Category</th>
<th>PERCENT OF CASES*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Judgment</td>
<td>86%</td>
</tr>
<tr>
<td>Communication</td>
<td>39%</td>
</tr>
<tr>
<td>Technical Skill</td>
<td>35%</td>
</tr>
<tr>
<td>Administrative</td>
<td>27%</td>
</tr>
<tr>
<td>Documentation</td>
<td>27%</td>
</tr>
<tr>
<td>Supervision</td>
<td>17%</td>
</tr>
</tbody>
</table>

* A case will often have multiple factors identified.

CBS N=761 coded PL cases asserted 1/1/06–12/31/10 with an obstetric treatment major allegation and obstetrics or midwifery responsible service.

### Categories of Contributing Factors

- Administrative (policy, staffing, …)
- Clinical Judgment
- Communication
- Documentation
- Supervision
- Technical

### TOP CLINICAL JUDGMENT FACTORS

- Selection/management therapy—labor and delivery
- Selection/management therapy—pregnancy

### TOP TECHNICAL SKILL FACTORS

- Technical performance
- Improperly utilized equipment
- Retained foreign body—surgical (surgical material/instruments)
The Model Methodology

The CRICO process for validating your malpractice risk

Dana Siegal RN, CPHRM

Director of Patient Safety, CRICO Strategies
Coding medical malpractice claims provides insight into the common causes of “unique” events.

- Lack of adequate assessment
- Failure to ensure patient safety
- Failure/delay ordering diagnostic test
- Failure to follow protocol
- Narrow diagnostic focus
- Resident Supervision
- Inadequate communication
- Failure to monitor physiological status

**UNIQUE EVENTS**

**NOT-SO-UNIQUE UNDERLYING ISSUES**
The Model Methodology: Data-driven Risk Mitigation

A six steps data-driven process for mitigating risk to your patients and providers

1. **capture**
2. **frame**
3. **ask**
4. **seek**
5. **act**
6. **measure**
Capture risk vulnerabilities as they occur

- Contemporaneous analysis of adverse event data, patient complaints, quality indicators, and themes from malpractice—*these provide “signals” for focused analysis*

Frame the data: Put them into context, develop hypotheses

- Integration of relevant denominator data, peer comparative data
  
  …*not just local, but national*

Ask: Are we still vulnerable?

- Assessment of present-tense risk— *focus groups, walk-rounds, risk assessments* to confirm / disprove hypotheses

Seek potential solutions

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

Act on the findings: Implement, educate, train

- Championship by high-level leadership to effect real change

Measure impact and develop metrics

- Measure the impact in the near term (with a predictive eye for the long term)
The Model Methodology: **Validation Phase**

Validating data signals to ensure focus on real risks to patients and providers

- **capture**
  - Adverse Events
  - RCAs (SREs)
  - Pt. Complaints
  - Quality Measures
  - Medical Malpractice

- **frame**
  - Denominators
  - Relevant Peer Comparisons
  - Clinical context
  - Financials

- **ask**
  - Focus groups
  - Walk Rounds
  - Culture Surveys
  - Risk assessment tools (RAP)

- **seek**
- **act**
- **measure**

**Signals**  **Validation**  **Intervention**
The Model Methodology: Intervention Phase

Implementing targeted solutions for successful risk mitigation

- Research solutions
- Create an inventory of models

- Pilots Programs
- Champions
- Spread Teams
- Grants
- Incentives

- Short-term metrics
- Long-term metrics

Signals → Validation → Intervention
Was the problem validated? … YES

Data captured several cases alleging negligence in performing laparoscopic surgery

Treated the small data set as an important signal

Now: need to sustain the consistent training

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

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 General Surgery departments to ensure durability

Signals | Validation | Intervention
Step 1: Capturing Risk Data

Richard Corder
Assistant Vice President, CRICO Strategies
The Model Methodology: **Capture**

Validating data signals to ensure focus on real risks to patients and providers

- **Capture**
  - Adverse Events
  - RCAs (SREs)
  - Pt. Complaints
  - Quality Measures
  - Medical Malpractice

- **Frame**
  - Denominators
  - Relevant Peer Comparisons
  - Clinical context
  - Financials

- **Ask**
  - Walk Rounds
  - Focus groups
  - Culture Surveys
  - Risk assessment tools (RAP)

- **Seek**
- **Act**
- **Measure**

Signals | Validation | Intervention
Good that you collected some useless data-stats for graphs etc., it shall keep everybody engaged in the presentation today.
1. Explain the shape of the graph.
A model patient safety profile
What is Data?

- A collection of facts
- Values or measurements
- Numbers
- Words
- Observations
- Characters and symbols
- Statistics
- Bits and bytes
- Qualitative and quantitative
- Discrete or continuous
Why collect data?

- Answer questions
- Encourage curiosity
- Permit and promote description and analysis
- Allow increased focus and clarity
- Validate assumptions
- Test hypotheses
- Track performance
- Identify trends
- Tell a story
- Defend a course of action
In the absence of data...

• We make assumptions
• We draw on our own biases
• We go with our “gut”
• We default to our “belief system”
• We have little frame of reference
• We don’t know how good we are
• We don’t know how to improve
• We don’t know where variation exists
• We don’t know what we don’t know
• We don’t have the full picture
What kind of patient safety data do you collect?

- Malpractice claims data
- Adverse event data
- Complaint data
- Root cause analysis data
- Safety event reporting system
- Surveys – patients and staff
- Patient comments
- Observations
- Executive walk rounds
- Patient and family advisory councils
- Others…
Different Data Sources Capture Different Aspects of an Event or Environment

- Executive Walk Rounds
- Medication Errors
- Environmental Hazards
- Route Cause Analysis
- Adverse Events
- Clinical Error
- Slips and Falls
- Malpractice Claims
- Patient Complaints
- Patient Harm
What are some of the collection barriers?

- Collection bias (history, small “n”, uniqueness)
- Collection tools (electronic, paper, memory…)
- Hierarchy
- Bureaucracy
- Geography
- A lack of knowledge
- Culture
How can you eliminate these barriers

- Education
- Data sharing
- Conversations
- Patient and provider safety agendas (stories)
- A modeled “just” culture
- From incident identification to signal detection
- From near miss observation to hazard reporting
- Good catches
In summary

Your data are telling you a story about patient safety and vulnerabilities. The more detail you have, through the deep coding of signals, the safer you and your patients will be.
Maximize your data capture

Some questions to think about, and answer

• What are you capturing?
• What are you missing?
• Do you know what you *should* capture?
• Is it easy to capture?
• Is it safe to capture?
• Is it easy to store your data?
• Can your data be aggregated?
• Can it be shared?
• Can it be reported?
• Can a story be told?
• Can you make care safer?
Step 2: Put data findings into context

Gretchen Ruoff, MPH, CPHRM
Program Director, Patient Safety Services, CRICO Strategies

Darrell Ranum, JD, CPHRM
Regional Vice President, Patient Safety, The Doctors Company
The Model Methodology: **Frame**

Validating data signals to ensure focus on real risks to patients and providers

- **Adverse Events**
- **RCAs (SREs)**
- **Pt. Complaints**
- **Quality Measures**
- **Medical Malpractice**

- **Denominators**
- **Relevant Peer Comparisons**
- **Clinical context**
- **Financials**

- **Walk Rounds**
- **Focus groups**
- **Culture Surveys**
- **Risk assessment tools (RAP)**
The ‘signals’ raised by analysis of malpractice data are **most compelling** when put into context by parameters that give a different, or broader, perspective.

1. Making Data Compelling
2. Making Data Relevant
3. Making Clinical Data Actionable
Obstetrics is among the organization’s top three most frequently named services.

All cases: Primary Responsible Services

Hospital B N=585 PL cases asserted 1/1/05–12/31/09.

Cases naming obstetricians account for half of the organization’s total incurred losses.

All cases: Primary Responsible Services

Hospital B N=585 PL cases asserted 1/1/05–12/31/09.

OB Case Rate has increased over recent years.

OB Case Rate per 1,000 Births:

Hospital B N=68 PL cases asserted 1/1/05–12/31/09 with OB or Midwifery as the primary responsible service and OB-related major allegation. Peers N=202 PL cases, asserted 1/1/05–12/31/09 with OB or Midwifery as the primary responsible service and OB-related major allegation. Peers are 20 teaching hospitals.
OB Case Rate has increased over recent years and varies notably from peers.

Peer Comparison: OB Case Rate per 1,000 *Births*:

Hospital B N=68 PL cases asserted 1/1/05–12/31/09 with OB or Midwifery as the primary responsible service and OB-related major allegation.

Peers N=202 PL cases, asserted 1/1/05–12/31/09 with OB or Midwifery as the primary responsible service and OB-related major allegation.

Peers are 20 teaching hospitals.
Diagnosis-related allegations drive Ferndean Hospital’s frequency and costs.

Top Major Allegations in Ferndean’s Cases

Ferndean Hospital N=75 PL cases asserted 1/1/06–7/31/11.
Total incurred includes reserves on open and payments on closed cases.
Diagnosis-related allegations are significantly more prevalent for Ferndean Hospital than its peers.

Top Major Allegations: Peer Comparison

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Ferndean Hospital N=75 PL cases asserted 1/1/06–7/31/11.
Peers N=2,516 PL cases asserted 1/1/06–12/31/10.
Putting Data into Context

Integrating peer comparative data

FROM:
"There are so few cases, and each is unique."

TO:
"Our case rate is twice that of our peers. We need to understand why, and take action."
Putting Data into Context
Integrating peer comparative data

FROM:
“Every organization struggles with this.”

TO:
“We are an outlier, and we need to take action.”
Strategically sharing the right data with the right audience creates relevance and engages them in creating a safer health care environment.

1. Making Data Compelling
2. Making Data Relevant
3. Making Clinical Data Actionable
Effectively driving changes in practice requires an understanding of needs and relationships.

<table>
<thead>
<tr>
<th>FRONT-LINE CLINICIANS</th>
<th>CLINICAL LEADERSHIP</th>
<th>EXECUTIVE LEADERSHIP</th>
<th>BOARD OF TRUSTEES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong></td>
<td><strong>Goal:</strong></td>
<td><strong>Goal:</strong></td>
<td><strong>Goal:</strong></td>
</tr>
<tr>
<td>• Engage</td>
<td>• Broaden perspective</td>
<td>• Understand significance within patient safety agenda</td>
<td>• Understand broad implications</td>
</tr>
<tr>
<td>• Increase awareness</td>
<td>• Understand significance</td>
<td>• Champion financial investment</td>
<td>• Champion adoption and spread</td>
</tr>
<tr>
<td><strong>Outcome:</strong></td>
<td><strong>Outcome:</strong></td>
<td><strong>Outcome:</strong></td>
<td><strong>Outcome:</strong></td>
</tr>
<tr>
<td>Improve safety of clinical practice</td>
<td>Empower providers to change practice</td>
<td>Implement safety initiatives</td>
<td>Drive accountability for change</td>
</tr>
</tbody>
</table>
Using the Right Data for Right Audience
Positioning resources

- RESPONSIBLE SERVICES
- PROCEDURE
  - DEVICE
  - MEDICATION
  - BODY PART
- FINAL DX and/or CLINICAL SEVERITY
- CONTRIBUTING FACTORS
- PROCESS OF CARE
- COMPARATIVE DATA - Internal
- COMPARATIVE DATA - External
- DIFFERENT AUDIENCES
  - Goals
  - Desired Outcomes
  - Defenses/Considerations
- RELEVANT DENOMINATORS
- CHRONOLOGICAL TRENDS
- INDEMNITY INCURRED BY CONTRIBUTING FACTOR
- INDEMNITY INCURRED BY PROCEDURE
- AVERAGE INDEMNITY
- MODEL INITIATIVES FOR PATIENT SAFETY

- AVERAGE INDEMNITY
Clinical data, positioned with denominators and comparisons, resonates with clinicians.

**FRONT-LINE CLINICIANS**

**Goal:**
- Engage
- Increase awareness

**Outcome:**
Improve safety of clinical practice

**Defenses/Considerations:**
- Protecting personal practice
- Lack of resources to change
- Question validity of data

**RELEVANT DENOMINATORS**

**RESPONSIBLE SERVICES**

**PROCEDURE DEVICE MEDICATION BODY PART**

**FINAL DX and/or CLINICAL SEVERITY**

**PROCESS OF CARE**

**COMPARATIVE DATA - Internal**

**COMPARATIVE DATA - External**
To drive change, clinical leaders need a broad perspective on causes – and impact – of claims.

**CLINICAL LEADERSHIP**

**Goal:**
- Broaden perspective
- Understand significance

**Outcome:**
Empower providers to change practice

**Defenses/Considerations:**
- Protect practice and providers
- Question validity of data
Illustrating the organizational impact of historic vulnerabilities empowers executive leaders to resource change.

**EXECUTIVE LEADERSHIP**

**Goal:**
- Understand significance within patient safety agenda
- Champion financial investment

**Outcome:**
Implement safety initiatives

**Defenses/Considerations:**
- Resource availability
- Protecting patients, providers
- Protecting reputation, minimizing cost

**RESPONSIBLE SERVICES**

**CLINICAL SEVERITY**

**CONTRIBUTING FACTORS**

**CHRONOLOGICAL TRENDS**

**RELEVANT DENOMINATORS**

**COMPARATIVE DATA - External**

**INDEMNITY INCURRED BY CONTRIBUTING FACTOR**

**INDEMNITY INCURRED BY SERVICE**

**AVERAGE INDEMNITY VS PEERS**

**MODEL INITIATIVES FOR PATIENT SAFETY**
Insight into pressing challenges and the significance of their impact compels boards to act.

**BOARD OF TRUSTEES**

- **Goal:**
  - Understand broad implications
  - Champion adoption and spread

- **Outcome:**
  Drive accountability for change

- **Defenses/Considerations:**
  - Protecting reputation, minimizing cost
  - Approach to creating change
  - Differences between hospitals across system

**RESPONSIBLE SERVICES**

**COMPARATIVE DATA - External**

**INDEMNITY INCURRED BY CONTRIBUTING FACTOR**

**CHRONOLOGICAL TRENDS**

**RELEVANT DENOMINATORS**

**AVERAGE INDEMNITY VERSUS PEERS**

**MODEL INITIATIVES FOR PATIENT SAFETY**
Contextualizing clinical data from the provider’s perspective is key for driving changes in clinical practice.

1. Making Data Compelling
2. Making Data Relevant
3. Making Clinical Data Actionable
Creating a multi-dimensional picture is critical to making clinical data actionable.

**Identify the setting**
- Office, surgery center, radiology department, patient room, etc.

**Define the sample**
- Claims based on diagnosis, procedure, age group, etc.

**Conceptualize what you see to help the audience understand**
- Timeline, e.g., Surgery
- Drill down, e.g., Emergency Medicine
- Process of care, e.g., Obstetrics
Surgery Data: Timeline
## Surgery Timeline

### Pre-Operative Phase
1. Patient meets with surgeon
2. Patient prepped for surgery

### Intra-Operative Phase
3. Initial phase of surgery
4. Open phase of surgery
5. Closing

### Post-Operative Phase
6. Post-anesthesia care
7. Surgeon meets with patient and/or family
8. Recovery phase in hospital
9. Recovery phase
10. Follow-up

### Miscellaneous
1. Credentialing
2. Documentation
Pre-operative Phase of Surgery

Examples of Case Types

Delay in diagnosis
- Bowel obstruction, intracranial bleeding, DVTs, etc.

Delay in treatment
- Watched breast mass, failure to communicate information, etc.

Inadequate assessment
- Patients were not appropriate candidates for the procedure
Post-operative Phase of Surgery

Examples of Case Types

Delay in diagnosis
- Hemorrhage, tissue necrosis, bowel leaks, peritonitis, etc.

Delay in treatment
- Infections, surgical relief of pressure from hemorrhage, returning to surgery for signs of peritonitis, etc.
## Financial Data for Claims

### Allegations by Each Step in Timeline

<table>
<thead>
<tr>
<th>ALLEGATION</th>
<th>INDEMNITY PER CLAIM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-operative Phase</strong></td>
<td></td>
</tr>
<tr>
<td>Failure to diagnose</td>
<td>$296,000</td>
</tr>
<tr>
<td>Failure to obtain consent</td>
<td>$109,000</td>
</tr>
<tr>
<td><strong>Intra-operative Phase</strong></td>
<td></td>
</tr>
<tr>
<td>Improper performance of surgery</td>
<td>$204,000</td>
</tr>
<tr>
<td>Retained foreign body</td>
<td>$101,000</td>
</tr>
<tr>
<td><strong>Post-operative Phase</strong></td>
<td></td>
</tr>
<tr>
<td>Improper management of surgical patient</td>
<td>$391,000</td>
</tr>
<tr>
<td>Unnecessary surgery</td>
<td>$228,000</td>
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</tbody>
</table>
Emergency Medicine Data: 
Drill Down by Age Group
The majority of claims come from patients between 40-49 years of age.

Claim Frequency by Age Group

<table>
<thead>
<tr>
<th>AGE GROUPS</th>
<th>Series1</th>
<th>Series2</th>
</tr>
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<tbody>
<tr>
<td>Unknown</td>
<td>53</td>
<td>7.8%</td>
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<tr>
<td>&lt; one year</td>
<td>25</td>
<td>3.7%</td>
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<tr>
<td>1-9 years</td>
<td>45</td>
<td>6.6%</td>
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<tr>
<td>10-19 years</td>
<td>53</td>
<td>9.0%</td>
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<tr>
<td>20-29 years</td>
<td>78</td>
<td>11.7%</td>
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<tr>
<td>30-39 years</td>
<td>97</td>
<td>14.5%</td>
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<tr>
<td>40-49 years</td>
<td>131</td>
<td>19.4%</td>
</tr>
<tr>
<td>50-59 years</td>
<td>106</td>
<td>14.7%</td>
</tr>
<tr>
<td>60-69 years</td>
<td>51</td>
<td>6.9%</td>
</tr>
<tr>
<td>70-79 years</td>
<td>34</td>
<td>4.8%</td>
</tr>
<tr>
<td>80+ years</td>
<td>8</td>
<td>0.9%</td>
</tr>
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</table>
Death is the most common injury in patients 40-49 years of age.
Final Injuries: 40-49 yrs

<table>
<thead>
<tr>
<th>FINAL INJURY</th>
<th>PERCENT OF CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>40%</td>
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<tr>
<td>Aggravated/worsened condition</td>
<td>12%</td>
</tr>
<tr>
<td>Infection</td>
<td>7%</td>
</tr>
<tr>
<td>Infarction</td>
<td>5%</td>
</tr>
<tr>
<td>Amputation-partial</td>
<td>3%</td>
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</tbody>
</table>
**Acute MI/Cardiac arrest is the most common final diagnosis in patients 40-49 years of age.**

*Final Diagnosis: 40-49 yrs*

<table>
<thead>
<tr>
<th>FINAL DIAGNOSIS</th>
<th>PERCENT OF CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute MI / Cardiac Arrest</td>
<td>10%</td>
</tr>
<tr>
<td>Intracranial / Subarachnoid Hemorrhage</td>
<td>7%</td>
</tr>
<tr>
<td>Acute CVA</td>
<td>3%</td>
</tr>
<tr>
<td>Malignant neoplasm of bronchus/lung</td>
<td>3%</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>3%</td>
</tr>
<tr>
<td>Septicemia</td>
<td>2%</td>
</tr>
<tr>
<td>Intraspinal abscess</td>
<td>2%</td>
</tr>
</tbody>
</table>
Observations from Data

• The largest number of claims come from patients in the 40-49 year old age group

• 40 percent of ED claims in this age group result from patient deaths

• Acute MI or cardiac arrest are the most common final diagnoses for patients in this group

• Question: What can we do to improve diagnosis and care for this group of patients?
Obstetrics: Process of Care
Seeing care from the patient’s perspective
Obstetrics Process of Care

<table>
<thead>
<tr>
<th>Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient arrives</td>
</tr>
<tr>
<td>2. Patient is assessed</td>
</tr>
<tr>
<td>3. Nurse and Physician communicate</td>
</tr>
<tr>
<td>4. Labor status is monitored</td>
</tr>
<tr>
<td>5. Patient delivers</td>
</tr>
<tr>
<td>6. Patient recovers</td>
</tr>
<tr>
<td>7. Patient is discharged</td>
</tr>
</tbody>
</table>
OB Process & System Failures

Patient admitted & assessed by nurse
Physician called; orders given
Nurse monitors patient’s labor
Nurse updates physician
Physician arrives
Patient delivers healthy infant

Nurse IDs complication
Physician called
Patient assessed; intervention performed
Intervention effective
Patient delivers healthy infant

Intervention not effective
Physician orders stat C-section
Patient delivers healthy infant

C-section delayed*
Compromised infant delivered

Physician refuses to come in
Nurse attempts intervention
Repeat call to physician Still refuses to come in
Nurse calls up chain of command

Leaders or back-up physician not available
Physician intervenes
Patient delivers healthy infant

Back up plan &/or intervention delayed.
Compromised infant delivered

Nurse fails to ID complication
Call to physician delayed
Intervention delayed.
Compromised infant delivered

*Factors that could delay an emergency C-section:
- Personnel are involved in another surgical procedure.
- OR not set up.
- Equipment malfunctions.
- Physician with C-section privileges is delayed.
Summary

• Signals raised by analysis of malpractice data can be **compelling** when contextualized by parameters that give a different, or broader, perspective.

• Strategically sharing the **right data with the right audience** creates **relevance** and engages them in creating a safer health care environment.

• Presenting data from provider’s perspective is key for **driving changes in clinical practice**
  - ✓ Create a picture.
  - ✓ Use case examples.
  - ✓ Tell the story.
Questions?
Step 3: Validate Your Risks

Workshop: Ambulatory Care

Richard Corder
Assistant Vice President, CRICO Strategies

Susan Abookire, MD
Chair, Department of Quality and Patient Safety, Mt. Auburn Hospital
The Model Methodology: **ASK**

Validating data signals to ensure focus on real risks to patients and providers

- **capture**
  - Adverse Events
  - RCAs (SREs)
  - Pt. Complaints
  - Quality Measures
  - Medical Malpractice

- **frame**
  - Denominators
  - Relevant Peer Comparisons
  - Clinical context
  - Financials

- **ask**
  - Focus groups
  - Walk Rounds
  - Culture Surveys
  - Risk assessment tools (RAP)

- **seek**
- **act**
- **measure**
Coding medical malpractice claims
Signals from the tip of the iceberg

- **Prioritizes** *where* to focus resources
  - Surgery, OB, ED, Nursing, medication issues
  - Frequency & volume, clinical severity, financial losses

- **Focuses** on *what* needs to be fixed
  - Technical: Misidentification vs. use of equipment vs. retained FB
  - Communication: provider-to-provider vs. provider-to-patient/family

- **Identifies** *who* is involved/can ID and implement solutions
  - MDs/Nursing leaders/service chiefs (lab/rad/enviro)

- **Supports** resourcing solutions; *how* can we make it happen
  - Leadership buy-in/financial support
### Key elements of coding:

**By clinicians for clinicians**

<table>
<thead>
<tr>
<th>Major Allegation (based on complaint, 1-1 ratio)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnosis-related events</td>
</tr>
<tr>
<td>• Surgical events (<em>non-anesthesia</em>)</td>
</tr>
<tr>
<td>• Medical treatment events</td>
</tr>
<tr>
<td>• Obstetrical events</td>
</tr>
<tr>
<td>• Safety &amp; security events</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsible Service (1 primary + secondary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary and secondary contributors</td>
</tr>
<tr>
<td>• Includes all providers in a specialty</td>
</tr>
<tr>
<td>• CRNA in Anesthesiology</td>
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<td>• NP in OB</td>
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</table>

<table>
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<tr>
<th>Contributing Factors (RN review, multiple)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinical judgment</td>
</tr>
<tr>
<td>• Clinical systems</td>
</tr>
<tr>
<td>• Communication</td>
</tr>
<tr>
<td>• Technical skill</td>
</tr>
</tbody>
</table>

<table>
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<th>What (is alleged to have) happened</th>
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</thead>
<tbody>
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<td>• delayed dx, missed dx, wrong dx, failure to dx</td>
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<tr>
<td>• skill based, retained FB, pt management post-op</td>
</tr>
<tr>
<td>• improper placement of C-line, improper choice of tx</td>
</tr>
<tr>
<td>• pregnancy, labor/fetal distress, delivery</td>
</tr>
<tr>
<td>• falls, enviro hazards, assaults (<em>non-employee</em>)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Who was the provider/service(s) involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency Service</td>
</tr>
<tr>
<td>• Radiology, Pathology, Nursing</td>
</tr>
<tr>
<td>• Medicine (Gen Med, Cardio, Hem Onc, Hospitalist...)</td>
</tr>
<tr>
<td>• Surgery (Gen Surg, Bariatric, Cardiac, Urology...)</td>
</tr>
<tr>
<td>• OB/GYN, Orthopedics, Neurosurgery</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Why it (might have) happened</th>
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</thead>
<tbody>
<tr>
<td>• narrow dx focus, no consults, patient monitoring</td>
</tr>
<tr>
<td>• scheduling, reporting results, follow up monitoring</td>
</tr>
<tr>
<td>• med record, informed consent, patient education</td>
</tr>
<tr>
<td>• improper use of equip, inexperience, poor technique</td>
</tr>
</tbody>
</table>
Ambulatory Cases

6,269 cases asserted 2006-2010

$985M total incurred losses
Distribution of claims across system

National Landscape: Claimant Type

CBS N=14,790 PL cases asserted 1/1/06–12/31/10. 459 cases (with patient type other or unknown) are excluded.
Distribution of major allegations in ambulatory cases

Top Major Allegations

CBS N=6,269 PL cases asserted 1/1/06–12/31/10 involving outpatients (and excluding location ED).
Total incurred includes reserves on open and payments on closed cases.
Steps in the diagnostic process of care in ambulatory cases
Diagnosis-related Outpatient Cases

<table>
<thead>
<tr>
<th>STEP</th>
<th>NUMBER OF CASES*</th>
<th>PERCENT OF CASES</th>
<th>TOTAL INCURRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient notes problem and seeks care</td>
<td>31</td>
<td>2%</td>
<td>$9,956,000</td>
</tr>
<tr>
<td>2. History/physical and evaluation of symptoms</td>
<td>472</td>
<td>28%</td>
<td>$199,150,000</td>
</tr>
<tr>
<td>3. Order of diagnostic/lab tests</td>
<td>875</td>
<td>52%</td>
<td>$330,621,000</td>
</tr>
<tr>
<td>4. Performance of tests</td>
<td>55</td>
<td>3%</td>
<td>$15,940,000</td>
</tr>
<tr>
<td>5. Interpretation of tests</td>
<td>559</td>
<td>33%</td>
<td>$227,644,000</td>
</tr>
<tr>
<td>6. Receipt/transmittal of test results</td>
<td>153</td>
<td>9%</td>
<td>$55,923,000</td>
</tr>
<tr>
<td>7. Physician follow up with patient</td>
<td>220</td>
<td>13%</td>
<td>$97,347,000</td>
</tr>
<tr>
<td>8. Referral management</td>
<td>370</td>
<td>22%</td>
<td>$127,040,000</td>
</tr>
<tr>
<td>9. Patient compliance with follow-up plan</td>
<td>222</td>
<td>13%</td>
<td>$46,072,000</td>
</tr>
</tbody>
</table>

*A case will often have multiple factors identified.

CBS N=1,699 PL cases asserted 1/1/06–12/31/10 involving outpatients (and excluding location ED) and a diagnosis-related major allegation.
Distribution of diagnoses – and cancer types – in ambulatory cases
Final Diagnosis in Outpatient Cases

CBS N=1,699 PL cases asserted 1/1/06–12/31/10 involving outpatients (and excluding location ED) and a diagnosis-related major allegation.
Ambulatory Care
From signals to validation

**Signals in Malpractice Data**
- 43 percent of cases occur in the outpatient setting
- Diagnosis-related claims are most prevalent in outpatient cases
- Breakdowns consistently occur at multiple steps in the diagnostic process of care
- 48 percent of diagnosis-related cases involved missed cancers

**Validating Signals, Testing Hypotheses**
- Does this reflect your clinical experience?
- What hypotheses did you draw?
- What resources do you have to test or confirm this hypothesis?
- Are there other signals to validate?
- Other hypotheses to test?
Step 3: Validate Your Risks

Workshop: Obstetrics

Heather Riah
Assistant Vice President, CRICO Strategies

Susan Mann, MD
Director of QI for OB/GYN, Beth Israel Deaconess Medical Center
The Model Methodology: **ASK**

Validating data signals to ensure focus on real risks to patients and providers

- **capture**
  - Adverse Events
  - RCAs (SREs)
  - Pt. Complaints
  - Quality Measures
  - Medical Malpractice

- **frame**
  - Denominators
  - Relevant Peer Comparisons
  - Clinical context
  - Financials

- **ask**
  - Focus groups
  - Walk Rounds
  - Culture Surveys
  - Risk assessment tools (RAP)

- **seek**

- **act**

- **measure**
**Coding medical malpractice claims**

**Signals from the tip of the iceberg**

- **Prioritizes** *where* to focus resources
  - Surgery, OB, ED, Nursing, medication issues
  - Frequency & volume, clinical severity, financial losses

- **Focuses** on *what* needs to be fixed
  - Technical: Misidentification vs. use of equipment vs. retained FB
  - Communication: provider to provider vs. provider to patient/family

- **Identifies** *who* is involved/can ID and implement solutions
  - MDs/Nursing leaders/service chiefs (lab/rad/enviro)

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  - Leadership buy-in/financial support
Key elements of coding:
By clinicians for clinicians

**Major Allegation** (based on complaint, 1-1 ratio)
- Diagnosis-related events
- Surgical events (*non-anesthesia*)
- Medical treatment events
- Obstetrical events
- Safety & security events

**Who was the provider/service(s) involved**
- Emergency Service
- Radiology, Pathology, Nursing
- Medicine (Gen Med, Cardio, Hem Onc, Hospitalist…)
- Surgery (Gen Surg, Bariatric, Cardiac, Urology…)
- OB/GYN, Orthopedics, Neurosurgery

**Responsible Service** (1 primary + secondary)
- Primary and secondary contributors
- Includes all providers in a specialty
  - CRNA in Anesthesiology
  - NP in OB

**Contributing Factors** (RN review, multiple)
- Clinical judgment
- Clinical systems
- Communication
- Technical skill

**What (is alleged to have) happened**
- delayed dx, missed dx, wrong dx, failure to dx
- skill based, retained FB, pt management post-op
- improper placement of C-line, improper choice of tx
- pregnancy, labor/fetal distress, delivery
- falls, enviro hazards, assaults (*non-employee*)

**Why it (might have) happened**
- narrow dx focus, no consults, patient monitoring
- scheduling, reporting results, follow up monitoring
- med record, informed consent, patient education
- improper use of equip, inexperience, poor technique
OB Cases

761 cases asserted 2006-2010

$463M total incurred
Trend of OB claims over last five years
Cases per 10,000 Births

*Due to incomplete coding of 2010 cases, the downward trend might be overstated.
CBS N=761 coded PL cases asserted 1/1/06–12/31/10 with an obstetric treatment major allegation and obstetrics or midwifery responsible service.
Distribution of top allegations

Allegations in OB Cases

CBS N=761 coded PL cases asserted 1/1/06–12/31/10 with an obstetric treatment major allegation and obstetrics or midwifery responsible service.
## Top five diagnoses

### Final Diagnoses in OB Cases

<table>
<thead>
<tr>
<th>FINAL DIAGNOSIS</th>
<th>PERCENT OF CASES</th>
<th>AVERAGE INDEMNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Asphyxia</td>
<td>28%</td>
<td>$1,437,000</td>
</tr>
<tr>
<td>Shoulder Dystocia</td>
<td>17%</td>
<td>$554,000</td>
</tr>
<tr>
<td>Intrauterine Death</td>
<td>5%</td>
<td>$347,000</td>
</tr>
<tr>
<td>Maternal Hemorrhage</td>
<td>4%</td>
<td>$471,000</td>
</tr>
<tr>
<td>Delivery Complications(Maternal)</td>
<td>3%</td>
<td>$952,000</td>
</tr>
</tbody>
</table>

CBS N=761 coded PL cases asserted 1/1/06–12/31/10 with an obstetric treatment major allegation and obstetrics or midwifery responsible service.
### National Landscape—Top Contributing Factors

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>PERCENT OF CASES*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Judgment</td>
<td>86%</td>
</tr>
<tr>
<td>Communication</td>
<td>39%</td>
</tr>
<tr>
<td>Technical Skill</td>
<td>35%</td>
</tr>
<tr>
<td>Administrative</td>
<td>27%</td>
</tr>
<tr>
<td>Documentation</td>
<td>27%</td>
</tr>
<tr>
<td>Supervision</td>
<td>17%</td>
</tr>
</tbody>
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CBS N=761 coded PL cases asserted 1/1/06–12/31/10 with an obstetric treatment major allegation and obstetrics or midwifery responsible service.

### TOP COMMUNICATION FACTORS
- Communication among providers—regarding patient’s condition.
- Communication—patient/family & provider—language barrier

### TOP TECHNICAL FACTORS
- Technical performance
- Improperly utilized equipment
- Retained foreign body—surgical (surgical material/instruments)

### TOP CLINICAL JUDGMENT FACTORS
- Selection/management therapy—labor and delivery
- Selection/management therapy—pregnancy
- Patient assess—misinterpretation of diagnostic studies
- Patient assess—failure/delay in ordering diagnostic test
Obstetrics
From signals to validation

**Signals in Malpractice Data**
- Labor and delivery-related allegations are most prevalent
- Case rate varies based on number of births per year
- Clinical judgment - most commonly identified causal factor
- Birth asphyxia and complications from shoulder dystocia are most common outcomes

**Validating Signals, Testing Hypotheses**
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- Other hypotheses to test?
Step 3: Validate Your Risks

Workshop: Surgery

Darrell Ranum  
Regional VP, Patient Safety, The Doctors Company

Dana Siegal RN CPHRM  
Director of Patient Safety, CRICO Strategies
The Model Methodology: **ASK**

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- Walk Rounds
- Culture Surveys
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Coding medical malpractice claims
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**Why it (might have) happened**
- narrow dx focus, no consults, patient monitoring
- scheduling, reporting results, follow up monitoring
- med record, informed consent, patient education
- improper use of equip, inexperience, poor technique
Surgical Cases
4,339 cases | 2006 - 2010
$730M total incurred
Rate of surgical cases asserted per 10,000 surgeries

Due to incomplete coding of 2010 cases, the 2010 rate might be overstated.

CBS N=2,588 Preliminary Coded PL cases asserted 1/1/06–12/31/10 with Surgery as the primary responsible service. Some clients are not included in this chart due to incomplete coding by assert years. Preliminarily coded cases have a responsible service or major allegation assigned.
Surgery is key driver of claims and dollars

National Landscape: Responsible Service

N=14,790 coded PL cases asserted 1/1/06–12/31/10.
*Other includes Allied Health, Non-Clinical, and Pharmacy.
Total Incurred= reserves on open and payments on closed cases.
Distribution of surgical allegations

Top Major Allegations

Top Surgery Allegations

CBS N=4,339 PL cases asserted 1/1/06–12/31/10 with Surgery as the primary responsible service.
Total incurred includes reserves on open and payments on closed cases.
Distribution of top services among surgical cases

Details of Responsible Service in Surgery

CBS N=4,339 PL cases asserted 1/1/06–12/31/10 with Surgery as the primary responsible service.
Total incurred includes reserves on open and payments on closed cases.
### Distribution of contributed surgery cases

#### Top Contributing Factors

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>PERCENT OF CASES*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Skill</td>
<td>50%</td>
</tr>
<tr>
<td>Clinical Judgment</td>
<td>49%</td>
</tr>
<tr>
<td>Communication</td>
<td>27%</td>
</tr>
<tr>
<td>Behavior-related</td>
<td>22%</td>
</tr>
<tr>
<td>Documentation</td>
<td>16%</td>
</tr>
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CBS N=4,339 PL cases asserted 1/1/06–12/31/10 with Surgery as the primary responsible service.

#### TOP TECHNICAL SKILL FACTORS
- Technical performance—misidentification of an anatomical structure
- Retained foreign body—surgical (surgical material/instruments)
- Technical performance—other

#### TOP CLINICAL JUDGMENT FACTORS
- Selection/management therapy—surgical/invasive procedures
- Patient assess—failure/delay in ordering diagnostic test
- Patient assess—failure to respond to repeated pt's concerns/symptoms
- Lack of/inadequate patient assessment—failure to note clinical info

#### TOP COMMUNICATION FACTORS
- Communication among providers—regarding patient’s condition
- Inadequate informed consent for procedures—surgical/invasive
- Communication—patient/family & provider
Surgery
From signals to validation

**Signals in Malpractice Data**
- Orthopedics and General Surgery are most frequently identified responsible services
- Improper performance of surgery is most common allegation
- Clinical Judgment is nearly as prevalent as Technical Skill as most commonly identified causal factors
- Surgical case rate may be declining over recent years

**Validating Signals, Testing Hypotheses**
- Does this reflect your clinical experience?
- What hypotheses did you draw?
- What resources do you have to test or confirm this hypothesis?
- Are there other signals to validate?
- Other hypotheses to test?
Step 4: Prioritize / Seek Solutions

Workshop Report-Out

Gretchen Ruoff, MPH, CPHRM
Program Director, Patient Safety Services, CRICO Strategies
Ambulatory Care
From signals to validation

**Signals in Malpractice Data**

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Validating Signals, Testing Hypotheses

• Does this reflect your clinical experience?

• What hypotheses did you draw?

• What resources do you have to test or confirm this hypothesis?

• Are there other signals to validate?

• Other hypotheses to test?
Step 5/6: Implement & Measure

Richard Corder
Assistant Vice President, CRICO Strategies
The Model Methodology: **Validation Phase**

Validating data signals to ensure focus on real risks to patients and providers

- **Capture**
  - Adverse Events
  - RCAs (SREs)
  - Pt. Complaints
  - Quality Measures
  - Medical Malpractice

- **Frame**
  - Denominators
  - Relevant Peer Comparisons
  - Clinical context
  - Financials

- **Ask**
  - Walk Rounds
  - Focus groups
  - Culture Surveys
  - Risk assessment tools (RAP)

**Signals** → **Validation** → **Intervention**
The Model Methodology: Intervention Phase
Implementing targeted solutions for successful risk mitigation

- Research solutions
- Create an inventory of models

- Pilots Programs
- Champions
- Spread Teams
- Grants
- Incentives

- Short-term metrics
- Long-term metrics

Capture
Frame
Ask
Seek
Act
Measure

Signals
Validation
Intervention
The Model Methodology

Next steps: Hazard identification and beyond

*Dana Siegal RN, CPHRM*

*Director of Patient Safety, CRICO Strategies*
Validate Your Malpractice Risk Questions?