Achieving the Outcomes We Deserve – How to Use Data and Best Practices Effectively

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CRICO Strategies

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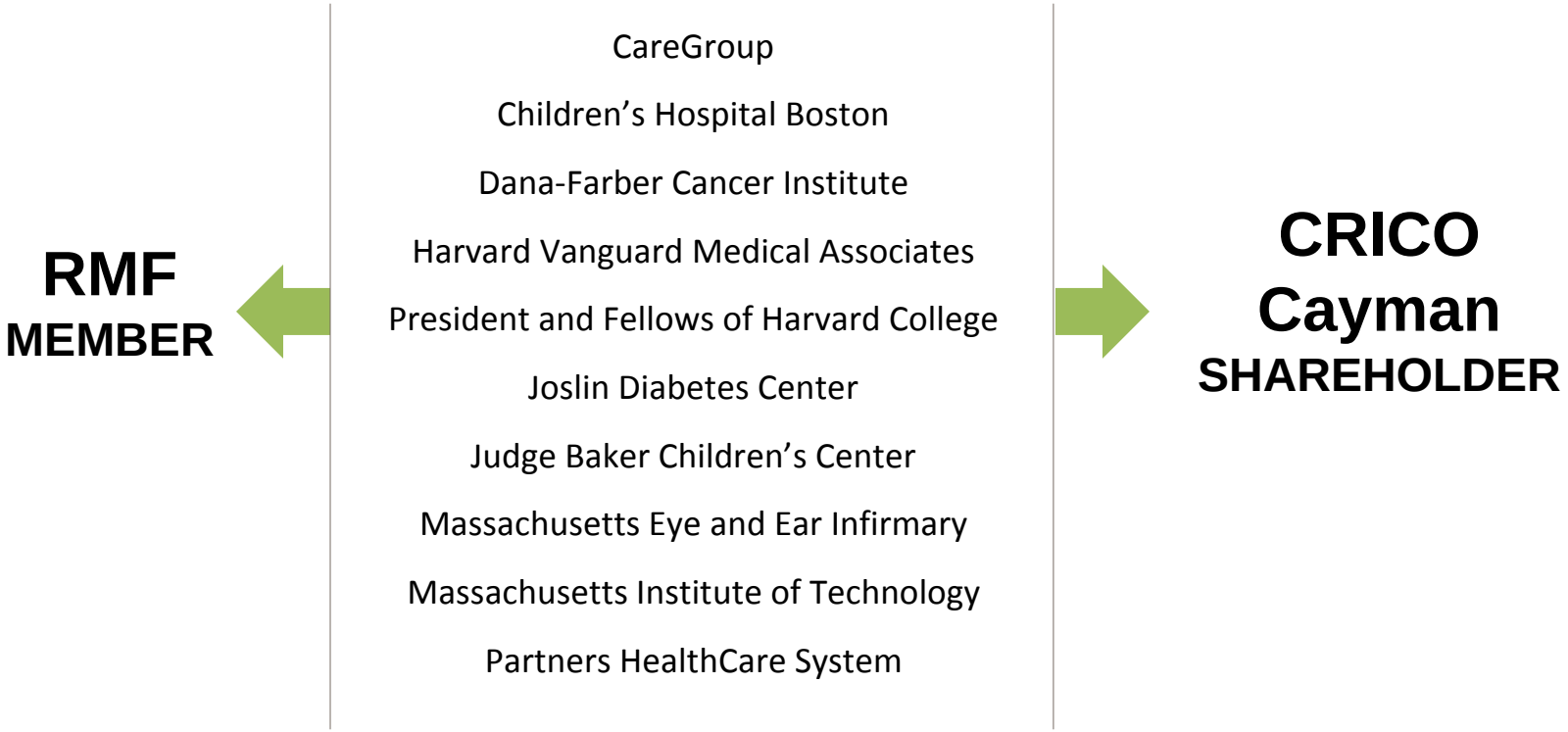
12th National Quality Colloquium


crico
Protecting Providers.
Promoting Safety.

Members are Shareholders



Protecting Providers - Promoting Safety

CRICO

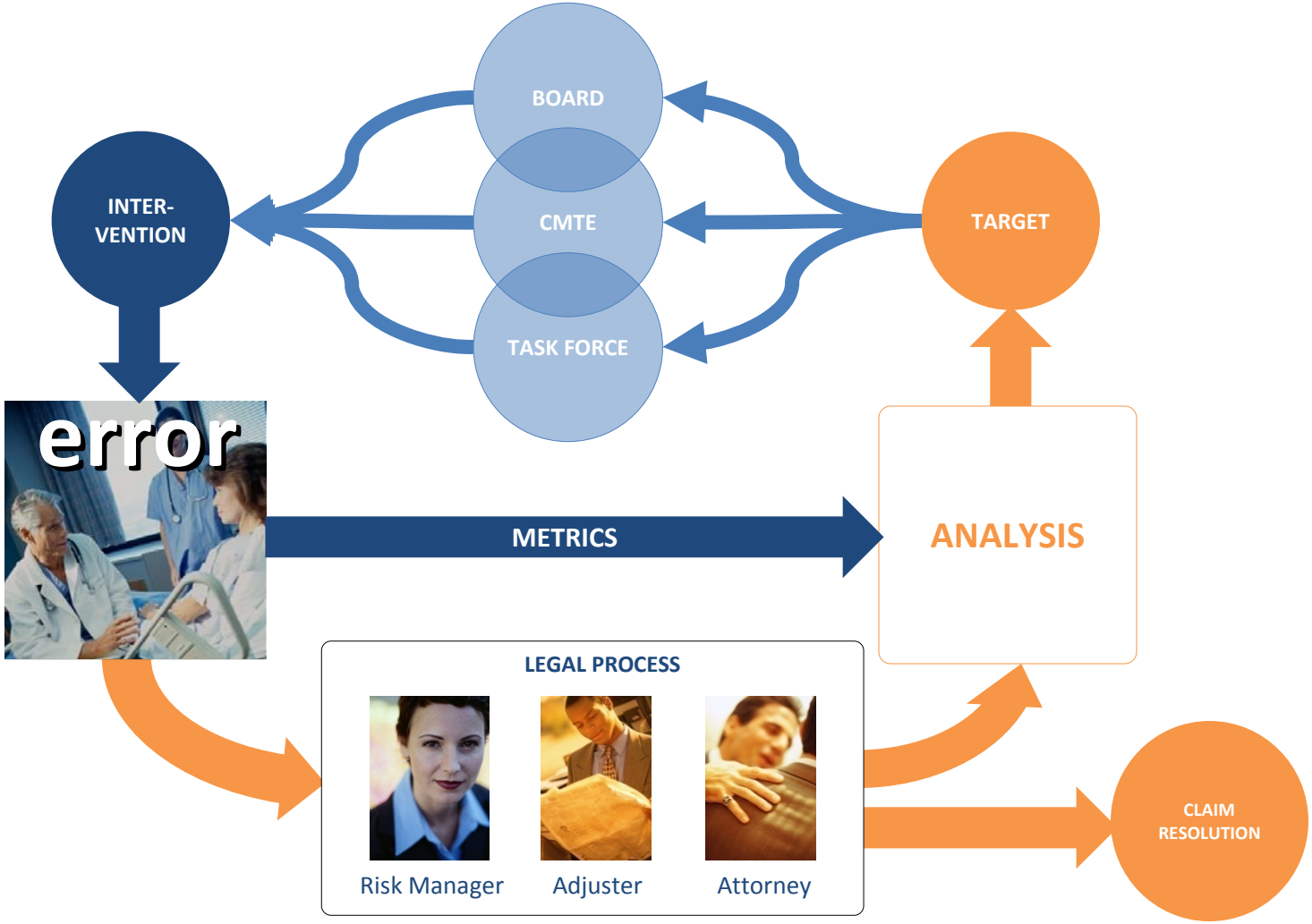
- Controlled Risk Insurance Co. (of the Harvard medical institutions)
- 35 years' proven success in data-driven risk management and patient safety
- Members
  - 26 hospitals
  - 100,000+ employees
  - 12,500 physicians
    - 3,600 residents and fellows

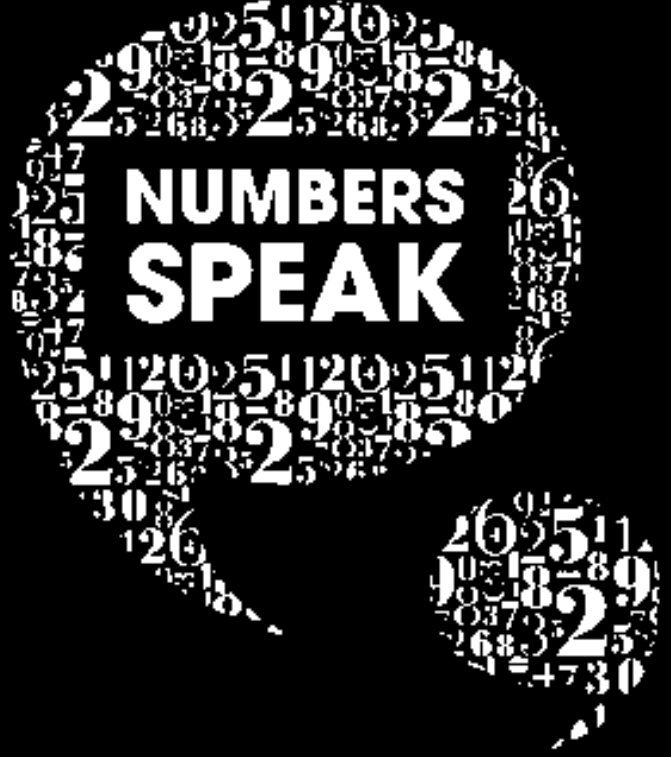
CRICO STRATEGIES

- 15 years as a division of CRICO
- Building a national community of data-driven risk intelligence
  - Comparative Data (CBS)
  - Community of Learning
- Partners
  - Healthcare organizations, captives, and insurers representing 500 hospitals and 125,000 physicians

Together we represent more than 500 organizations and a database of more than 260,000 medical malpractice claims

Using analyzed data to effect change



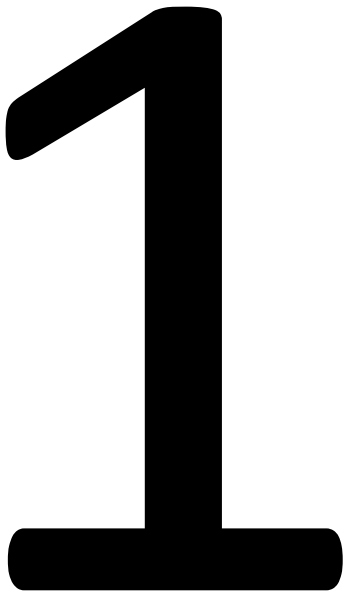

NUMBERS
SPEAK

Our data base has an exponential impact…

10 years of data…

- CRICO: 2,400 closed cases
- OBS: 30,000 closed cases
- All: 260,000 cases

Sometimes all you need is an n of…



Just an FYI -

I lost my
23-year old Son (only child)
3 years ago shortly
after I was hired.
Lack of Communication
was the problem and
no transparency.
(Simple Appendectomy)

Leading causes of death in US

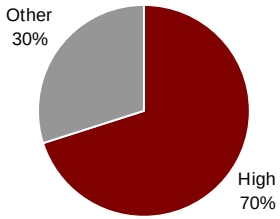
1. Heart disease: 599,413
2. Cancer: 567,628
3. Chronic lower respiratory diseases: 137,353
4. Stroke (cerebrovascular diseases): 128,842
5. Accidents (unintentional injuries): 118,021
6. *Medical Error: 44,000 to 98,000*
7. Alzheimer's disease: 79,003
8. Diabetes: 68,705
9. Influenza and Pneumonia: 53,692
10. Nephritis, nephrotic syndrome, and nephrosis: 48,935
11. Intentional self-harm (suicide): 36,909

Anesthesia premiums were among the highest, and climbing…	A tragic event becomes the burning platform that impels change…
Analysis identified both technical and process problems.	42% of all OB cases involved teamwork-related failures.
Anesthesia Errors	**Tragedy in OB**
Standards + Simulator Training + Premium Incentives	Simulation + Team Training + Premium Incentives
25% premium rate differential for anesthesiologists with training vs. those without.	Reduction in number and severity of OB cases.

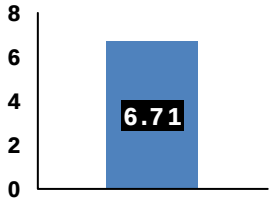
OB Experience: Before and After

Injury Severity: Before Training
1/1/98–6/30/03

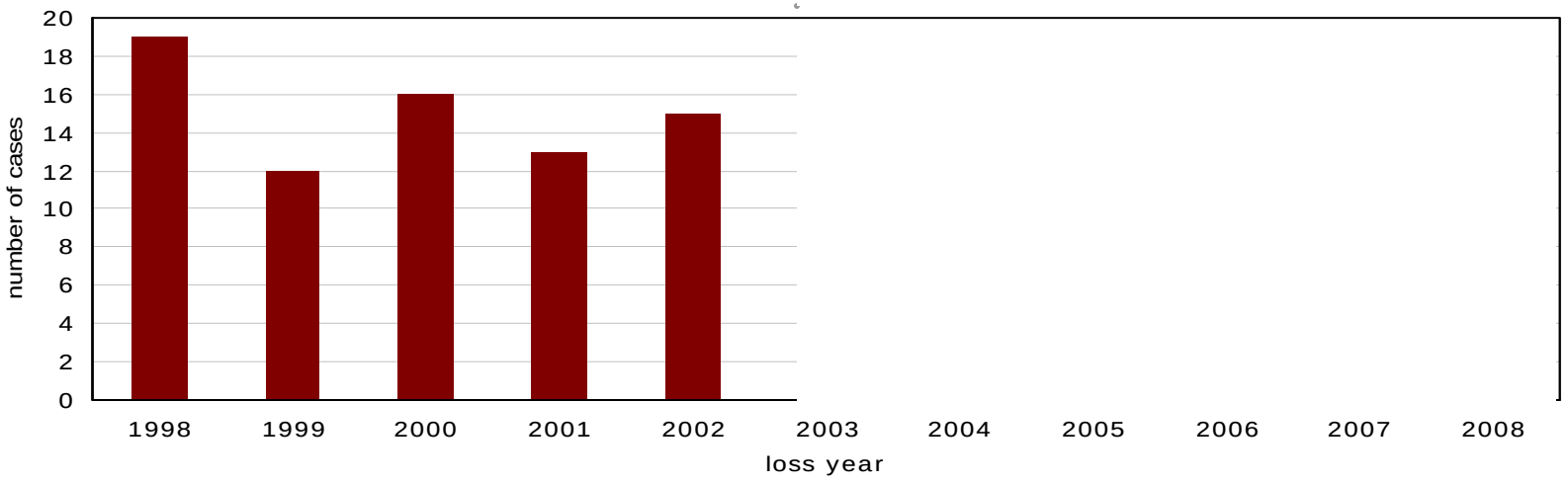
% of Cases



Case Rate per 10,000 births



Injury Severity: After Training
7/1/03–10/1/08



N=113 PL cases occurring 1/1/98–10/1/08 with an obstetrics-related major allegation.

FOCUSED ANALYSIS: OBSTETRICS

Allegations inc management of both pregnancy and labor

Major Allegations in Obstetrical Cases

factor	number of cases	total incurred
OB-related Treatment	52	$32,041,363

OB-related treatment—details	number of cases	total incurred
improper management of pregnancy	20	$10,325,639
delay in treatment of fetal distress	10	$14,426,743
improper performance of vaginal delivery	9	$4,875,000
improperly managed labor—other	5	$2,343,621
OB-related treatment—other	3	$985,684
delay in delivery (induction/surgery)	2	$3,750,000
improper performance of operative delivery	2	$650,000
improper choice of delivery method	1	$1,015,000

N=52 QHS PL cases asserted 1/1/07–12/31/09 with OB/MW as the responsible service or an obstetrics-related major allegation.

Improper Management of Pregnancy is significantly higher for QHS than academic peers

Comparing Allegations: Academic Medical Centers

	Academic Medical Centers	
Allegation	**QHS**	**Peers**
Improper management of pregnancy	42%	14%
Delay in treatment of fetal distress	25%	21%
Improper performance of vaginal delivery	16%	14%
Delay in delivery (induction/surgery)	8%	7%
OB-related treatment—other	7%	12%
Improperly managed labor—other	7%	13%
Improper performance of operative delivery	5%	9%
Improper choice of delivery method	3%	8%

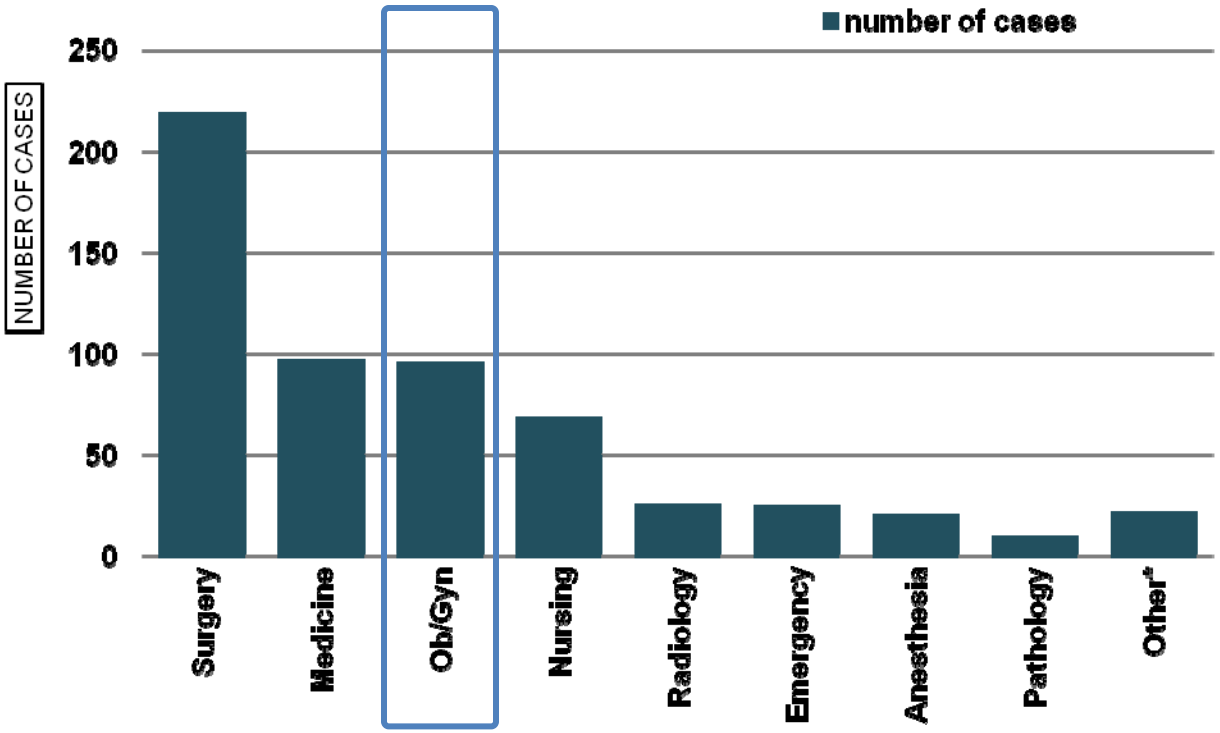
QHS AMCs N=32 PL cases asserted 1/1/07–12/31/09 with obstetrics-related major allegation.
Peer AMCs N=76 PL cases asserted 1/1/07–12/31/09 with obstetrics-related major allegation.

585 CASES

$287M TOTAL INCURRED

Obstetrics is among the organization's top three most frequently named services.

All cases: Primary Responsible Services



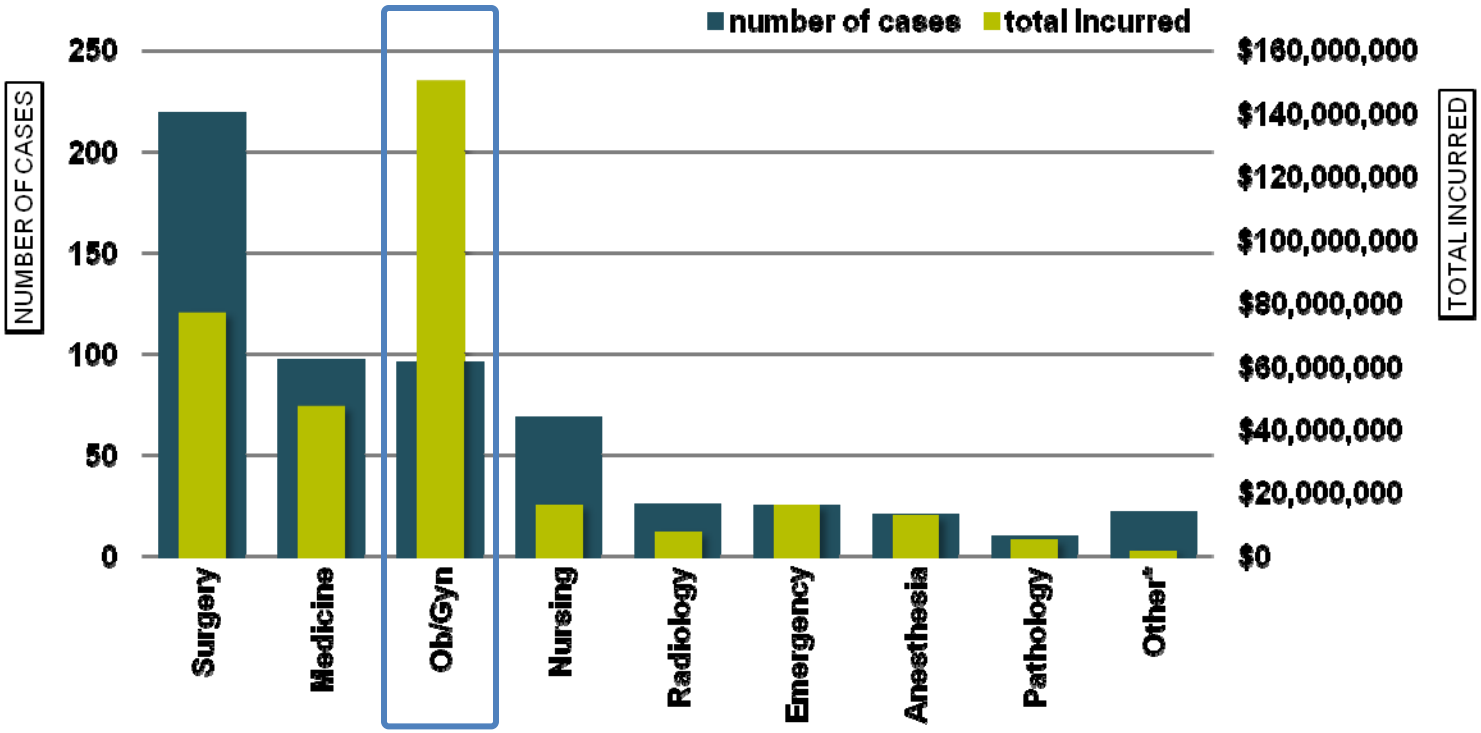
Hospital B N=585 PL cases asserted 1/1/05–12/31/09.

*Other includes Allied Health, Psychiatry, Oral Surgery/Dentistry, Pediatrics/Neonatology, and Pharmacy.

585 CASES
$287M TOTAL INCURRED

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

All cases: Primary Responsible Services



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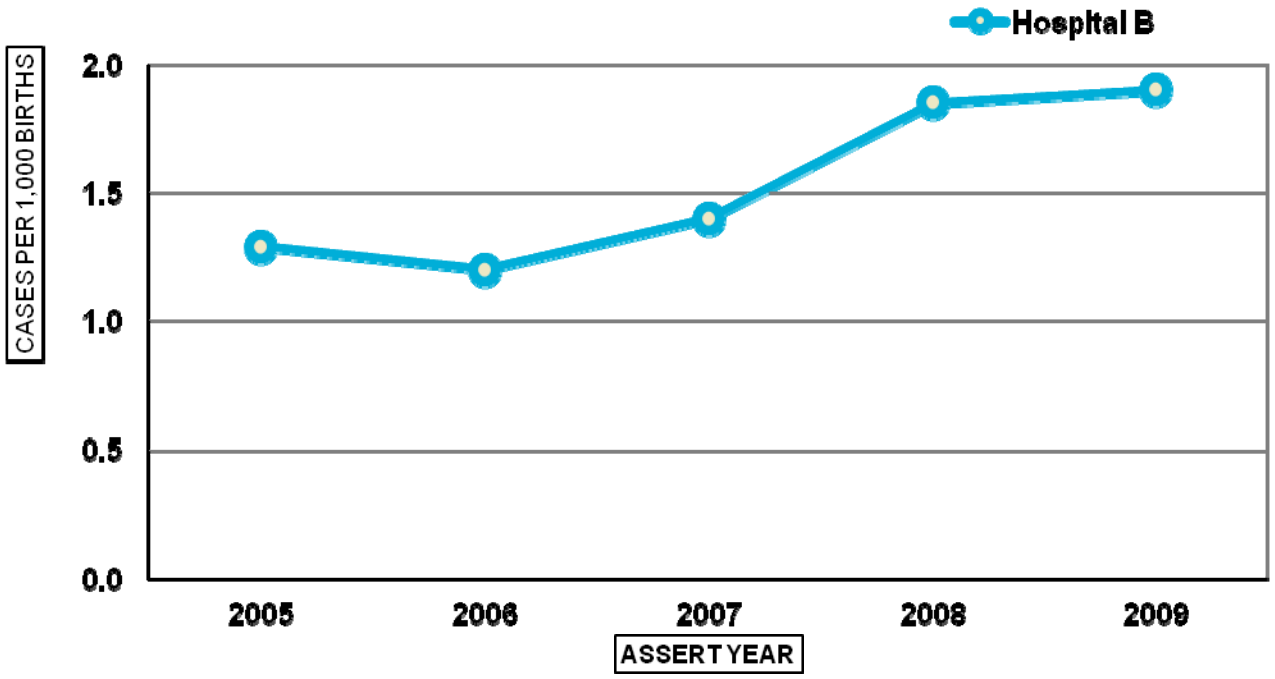
OB Case Rate has increased over recent years.

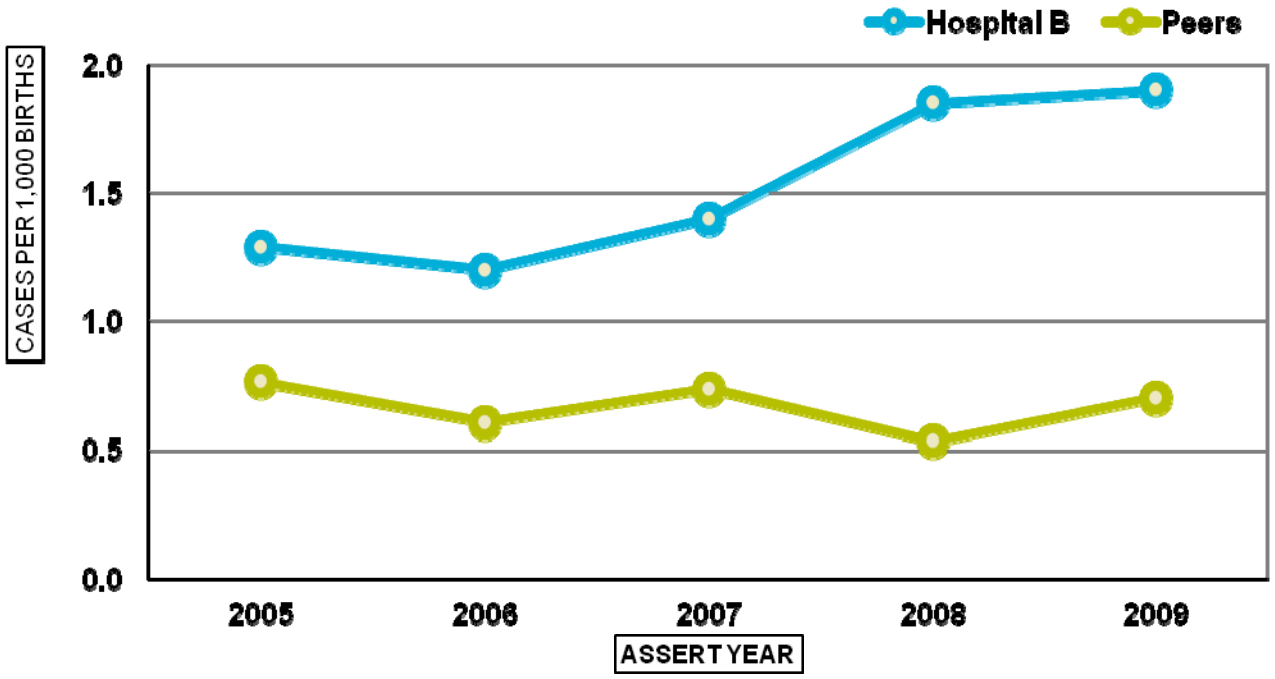
OB Case Rate per 1,000 **Births:**



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:**



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Putting Data into Context

Integrating peer comparative data

FROM:

There are so few cases, and each is so 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:

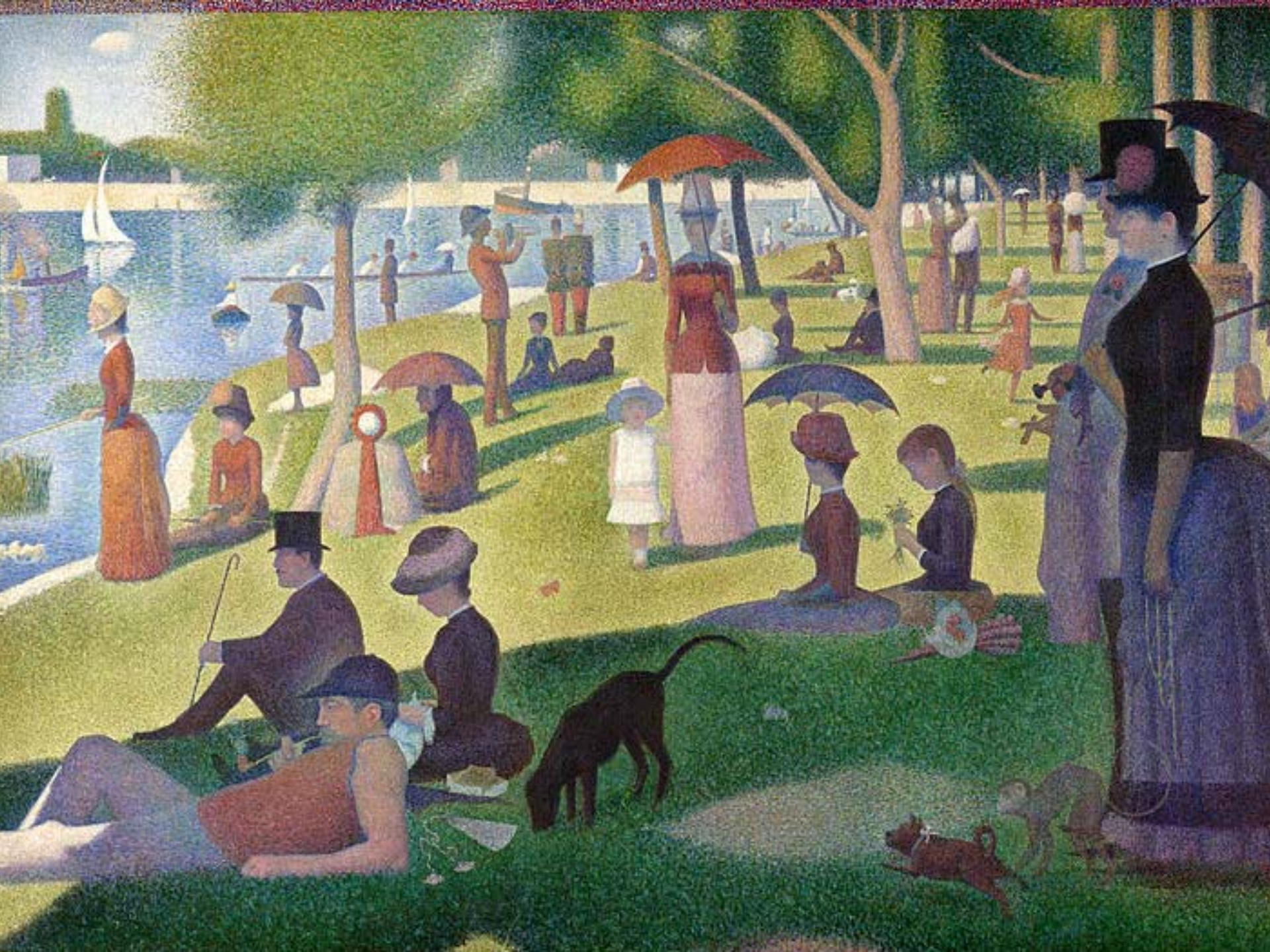
We are an outlier, and we need to take action.

What if we don’t “see” what others “see”

Is it safe to ask for clarity?

Are we all looking at the same data the same way?


FedEx



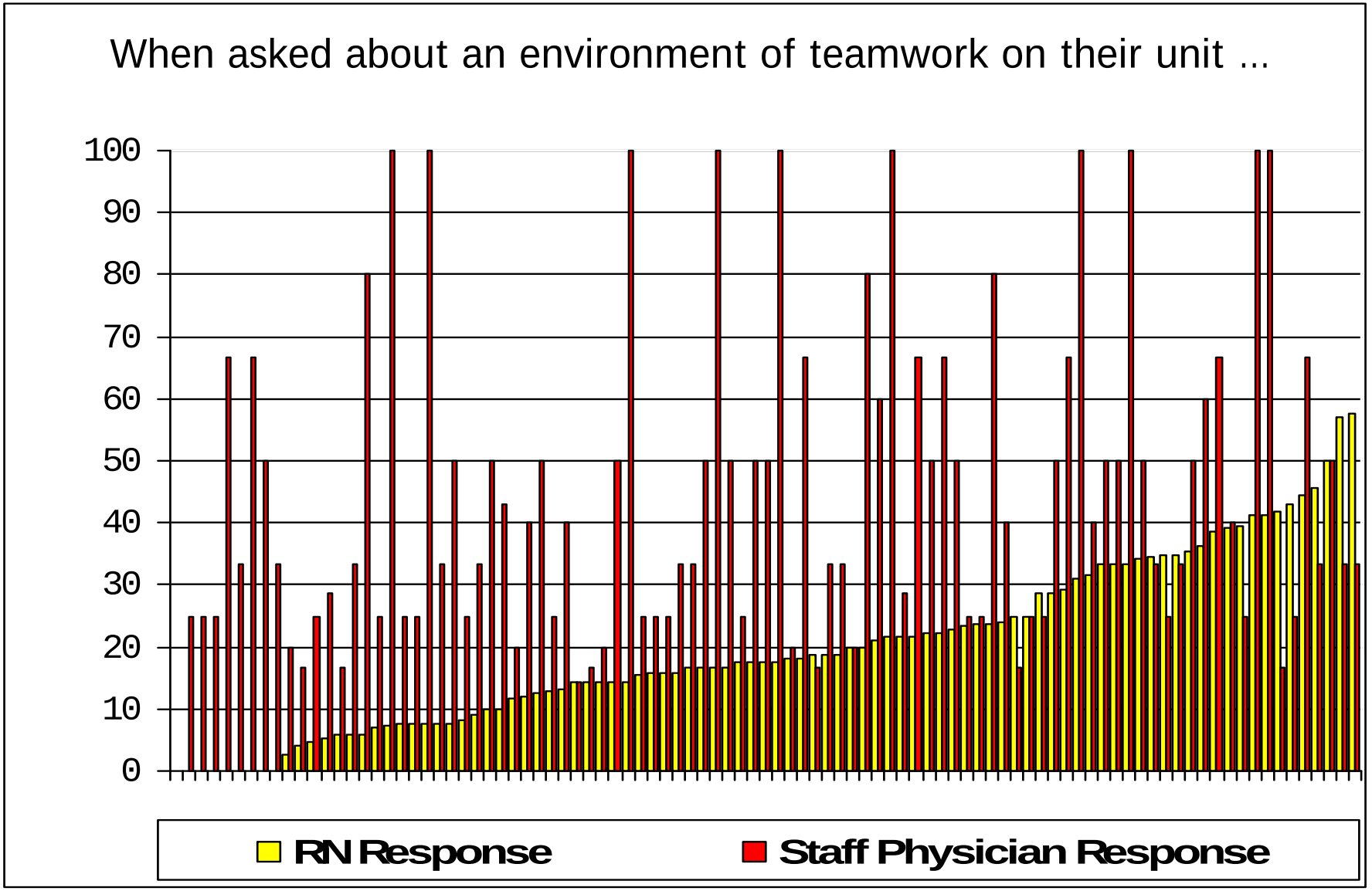

Sprite
®

On assumptions…

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

Sir Arthur Conan Doyle

Teamwork is in the Eye of the Beholder



OB Case Rates per 10,000 births – 2007-11

For hospitals in CBS with >3,000 births

		Five Year Mean Annual Birth Count	OB Case Rate per 10,000 births
1	Hospital A	*4,895*	1.2
2	Hospital B	*3,661*	2.2
3	Hospital C	*3,312*	2.0
4	Hospital D	*4,152*	4.3
5	**Hospital E**	***4,828***	***4.6***
6	Hospital F	*5,087*	5.5
7	**Hospital G**	**3,873**	**5.7**
8	**Hospital H**	**3,475**	**5.8**
9	Hospital I	*5,137*	6.6
10	**Hospital J**	***8,097***	***6.7***
11	Hospital K	*3,883*	6.9
12	Hospital L	*3,040*	8.6
13	Hospital M	*4,546*	9.7
14	Hospital N	*3,013*	10.0
15	Hospital O	*4,976*	10.5

Using data to Enagage

Malpractice Litigation

Patient complaints predict malpractice events: *MGPO CRICO Review: 3 unsolicited patient complaints in 2 years = 4 X risk of being named in a malpractice suit*

8% of physicians account for over **50%** of claims

The most important factor in predicting who will sue:

…the quality of the relationship between the patient and doctor

The Physician Perspective

Percent of physicians that believe communication is as important as technical skill in contributing to patient outcomes

83%

Percent of physicians that believe they have had good training in patient communication

18%

Ashbury et al. *Physician Communication Skills: Results of a Survey of General/Family Practitioners in Newfoundland*. Med Educ Online [serial online] 2001; 6:1.

Listening

Physicians interrupt patients an average of **18 seconds** after the patient begins to speak

Once interrupted, patients rarely expressed true concerns

Given time to express all concerns, patients needed no more than

150 seconds (2.5 minutes)

Annals Intern Med. 1984; 101; 692-696

Percentage of patients that are interrupted by physicians giving the initial history

74%

Average time of interruption

16.5 seconds

J Gen Intern Med 2005; 20(3):267-270

To sit or not to sit…

When the provider sits down - patients overestimated time by

15%

When the provider is standing - patients underestimated time by

7%

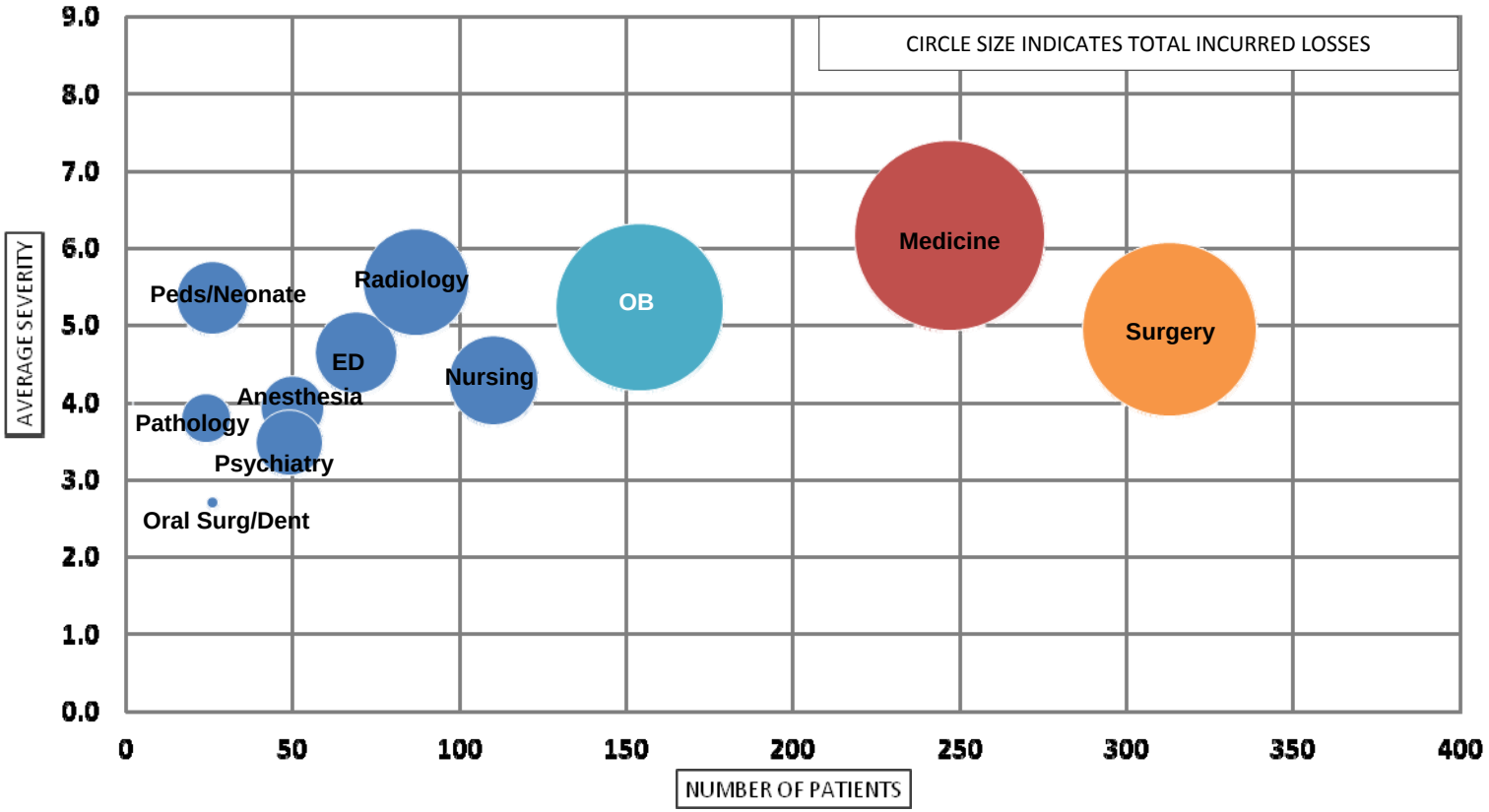
Providers (sitting or standing) overestimated time spent with their patients by

6%

Annals of Emergency Medicine 2007

Hot Spots for Patient Safety

Top Responsible Services in Cases Asserted 2007–Q1 2012



CRICO N=1,189 PL cases asserted 1/1/07–3/31/12.
Total Incurred=reserves on open and payments on closed cases

A shift in mind-set

- **Responsibility** – a before the fact mindset of personal ownership and commitment to a result
- **Self-Empowerment** – taking personal action and risk to ensure an agreed upon result
- **Personal Accountability** – a willingness, after the fact, to answer for the outcomes produced

Lessons

- Start by looking in the mirror
- Listen
- Get clarity
- Make friends
- Don’t over complicate
- Repeat

Thank you!

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