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physician insurer

AND

How to Identify, Help Disruptive Physicians

Combined Ratio: Can Insurers Keep It from Climbing?

Interview

With Robert Hanscom, Vice President, CRICO/RMF Strategies

CRICO/RMF is the patient safety and medical liability insurance company owned by and serving the Harvard medical community since 1976. That community is comprised of 29 hospitals and medical schools and their associated 11,500 physicians, as well as 240 other healthcare organizations. Medical liability insurance is provided by the Controlled Risk Insurance Company of Vermont, Inc. (a risk retention group), and PIAA member Controlled Risk Insurance Company, LTD (CRICO). The Risk Management Foundation of the Harvard Medical Institutions was incorporated by the Harvard medical institutions in 1979 as a charitable, medical, and educational membership organization (CRICO/RMF).

In 1988, the establishment of CRICO/RMF Strategies created new partnerships among physicians, healthcare systems, and their MPL insurers. CRICO/RMF Strategies is a leader in evidence-based risk management, having 25 years of claim-based data derived from the experience of the Harvard medical community to assist its physicians and institutions in their goal of delivering the safest healthcare in the world. Like the PIAA, CRICO/RMF Strategies uses medical professional liability data to help healthcare organizations reduce medical errors and enhance patient safety. *Physician Insurer* asked CRICO/RMF Strategies Vice President, Robert Hanscom, to tell us about how his operation works.

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Q: What sorts of data are being analyzed—can you provide us an overview of the fields being collected?

A: We code every claim for many factors, but the key elements include: plaintiff's allegation, responsible service (including primary and secondary providers), procedure(s) done, contributing factors, injury severity, and both admitting and discharge diagnoses. The most important of these is the capture of contributing factors, or as others refer to them, "risk management issues." These factors are determined by registered nurse coders who review both clinical and claims information to identify the key issues impacting the case. Factors identified include issues such as providers' clinical judgment, communication with the medical team and/or patient, technical error, and issues related to supervision of clinical staff.

In addition, as we look to compare organizations nationally, we're adding more and more denominator data with the goal of adding more context to the findings that we share. Being able to show comparative rates is very compelling to a clinical audience.

Q: What methods are you using for analysis, at this point?

A: We use a variety of methods, including the mathematical and statistical approaches used by any group that analyzes data. The statistical data have been very interesting, because normally what we do is look for trends, for variances, for outliers. Those comprise our routine approach to analysis.

But a little over a year ago, we entered a new area: predictive analytics.

We are hoping that predictive analytics will give us a more proactive sense as to the true significance of these data, in terms that will be directly useful to our audience.

Q: Will this be something that will be published in the scientific literature?

A: Yes. But right now, we are experimenting internally here, running some demonstrations based on what we have found. From a statistical standpoint, malpractice data reflect a small body of information, so small that it defies statistical significance. For all the press that it gets, malpractice is still a relatively rare event, when considered against the denominator of the total amount of healthcare given on a daily basis.

However, these data are very rich and serve as a valuable guide to where the vulnerabilities are in healthcare. So we feel very strongly that this data needs to be used in the most optimal way. We are

very eager to see if we can apply new statistical methodologies that will allow us to make it a much more usable source of intelligence.

Although healthcare entities collect a lot of routine data, it is the malpractice case studies that highlight what that data collection is in fact missing. If you think about, for example, missed or delayed diagnoses of cancer, the data that are being collected by hospitals on a routine basis fail to capture the vulnerabilities driving diagnosis-related incidents. There is really no knowledge about it, until much later, and the real-time element has been completely forgotten or lost.

Q: Other than publishing in academic journals, how do you think your findings should be disseminated to physicians?

A: The most important thing is to get this critical information in front of physicians and the key risk and safety leaders who can drive change in an organization. We have an approach that we have been developing in our institution over the years to ensure that the data are used in a way that prioritizes needs and drives decision-making in a focused and productive way. It's a six-step approach or methodology, as we call it, and we've found it to be very effective.

The first step in our methodology is to look for causes—to analyze as deeply as possible every single malpractice claim that comes in. We don't believe that there are any claims that have no merit. We think that every claim needs to be looked at and understood—even the ones that appear to be frivolous. We always find issues—we always find reasons why these malpractice claims were brought. As our clinicians code the claims, they put all of the data into our database, aggregating those themes in whatever way makes the best sense. After we've done the examination of causes and the comparisons, we generate hypotheses about where the risk might still exist.

Once we form hypotheses about risk, we use focus groups of physicians from our institutions, or we perform assessments to understand if these risk factors are still in play.

Physicians respond positively to this approach. They feel that we've really taken a good hard look at what has happened in these malpractice cases, and that this information will help them avoid getting caught in these cycles of malpractice again.

Once we've finished the validation on whether these factors are still active, we sometimes discover that the problems that led to the claims have been solved and, likely, there won't be any more claims linked to them. But more often than not, the problems have not been resolved. They may have taken a different form, but they are still out there.

What we are doing is trying to collect the responses of groups that address, very specifically, the drivers of malpractice—in particular, the high-severity-injury cases. What is really pushing those cases forward? What is causing those cases?

Q: Can you benchmark the progress of the organizations?

A: Actually, we are trying to benchmark their progress. For each of our CRICO-insured organizations, we have developed a series of report cards, whereby we gauge their improvement efforts on some key fronts. The target areas that we are most focused on are surgery, diagnosis, obstetrics, medication errors, and emergency medicine. With surgery, there are a number of key characteristics that we think any surgical department needs to be implementing to ensure that they are doing everything they can to combat the very severe cases and, we hope in the long term, MPL activity as well.

We have a report card for these indicators, and another one for diagnosis—how to avoid missed or delayed diagnosis, listing the key characteristics that any healthcare entity needs to really have in place in order to make sure that avoidance of missed diagnosis is as robust as possible. We have similar ones for obstetrics, medication error, and emergency.

With our report cards, what we do is try and gauge the progress that each organization is making in implementing specific solutions. Then we compare how the various organizations are doing against one another to use the results as a motivator.

Our goal is to provide every organization with highly reliable data intelligence on which to build its risk and patient safety programs. We sometimes worry that somehow they will think that we are seizing their patient safety agenda. But we have never had that reaction from any of the groups we've worked with. They have always been very appreciative that we are helping them move their safety agenda forward.

If we started preaching to them, or demanding that they do certain things, I think we would have a different reaction. But we have never approached it that way. We try to remind them that we want to be a partner to them. We have defendable data. There is financial loss associated with the data, as well as human tragedy. We really want to make sure that it is used in the best possible way.

Our institutions believe that our analysis and recommendations help them concentrate on what is critical, because the MPL data clearly represent the worst of the worst. It is common ground: Everyone can agree that you really want to avoid that kind of scenario.

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Improving Obstetrical Care and Collaborating on Surgery

In November 2000, a large academic organization became concerned about its obstetrical care after a major incident occurred: an infant died. An analysis of 10 years of OB data revealed that nearly half of all medical professional liability claims in the years 1990-2000 could have been prevented or mitigated by better teamwork. The most common team-related difficulties were failure to cross-monitor in more than three-fourths of the incidents, and poor communication between providers in two-thirds.

The intervention chosen to address this problem was a team training program based on "crew resource management," a theory borrowed from the airline industry. To many people, this theory has devolved into a simple concept of checklists. But in fact, introducing it and practicing it involves a significant change in the entire culture of an organization. For the obstetrical unit, the core elements of crew resource management were customized and expanded, to accommodate the unique setting of the OB unit. To date, nearly 30 hospitals have been trained in this approach via a customized program,"Team Performance Plus."

The cultural change was necessitated, in part, because physicians and nurses, throughout the long course of their training, are so busy becoming great as individuals, they may not devote sufficient time in learning how to become a part of an effective, closely coordinated team.

For example, at each shift change, after the individual staff changes and reports have been completed, the entire team gathers to discuss how best to manage all of the patients throughout the upcoming hours. If there are major changes in patients during the course of the shift, a team "huddle" is recommended. For instance, if four emergency caesarian sections are anticipated, instead of the previously assumed two, staff assignments can be updated appropriately. The training required for high-functioning teams is a year-long process, and continues until it has become integral to the work of the entire staff.

The skills learned from Team Performance Plus have resulted in significant improvement in the reduction of adverse outcomes across a broad range of practices within the OB unit.

The Power of Collaboration: Surgery

To try and understand the factors that led to surgical errors, CRICO/RMF looked into its data and found that one of the two most common causes of major errors that resulted in harm to patients is a communication breakdown. The data showed that many problems occurred in the post-operative arena, when patients were recovering from major surgery and being cared for by residents. When issues arose, such as post-operative bleeding, the residents were opting to manage these events themselves instead of escalating the problem to the attending, who could assist them in determining the best actions to take. What the claims data revealed was that there had been a critical lapse in communication between residents and their attending physician.

One of the reasons this problem occurred is that residents tend to feel that they should be taking care of patients on their own. Many think it is a sign of weakness if they consult the attending, or fear that there will be an angry response if they call the attending in the middle of the night: "Why are you waking me up? That's a stupid question."

To obviate this confusion, several chiefs of surgery convened and came up with a simple, yet effective solution: a specific list of rules that identify changes in a patient's condition that require the resident to contact the attending to discuss the plan of care. The list is printed on a laminated card that features a slot at the top, so the doctor can slide it through and suspend the cards from an ID badge, like keys on a key ring.

Know as "trigger cards," these simple cards establish an expectation of open and frequent communications between a resident and the attending physician—all with the goal of enhancing patient care. For example, one "trigger" might state that if a patient's blood pressure drops to a certain level, the resident must notify the attending.

The cards eliminate all of the personality conflicts, all of the second-guessing, and set down a set of clear rules and standard of care. Sets of customized cards have been created for each participating organization and specialty, for example, Pediatric Cardiology and OB/Gyn.

Today, every surgical resident at Harvard's four major teaching hospitals carries this card, which serves to reduce communication breakdowns, improve patient safety and ensure that strong communication is embedded into the hospitals' culture. PIAA