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Solutions by CRICO

Sample Client Analysis:
Diagnostic Claims in the Ambulatory Setting

Prepared for: Candello CLIENT

Commercial insurer of non-academic hospitals and physician practice groups with numerous organizations across several states

The Largest and Deepest Source of MPL Data and Learning in the U.S.

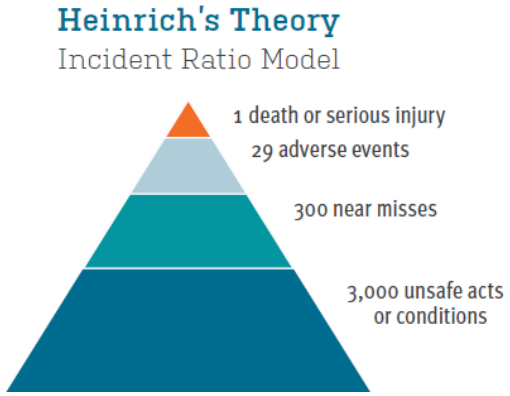
- A national data collaborative that shares a database of medical professional liability (MPL) claims
- Identify clinical and financial trends and correlations that impact patient safety and business performance
- Built by CRICO, the MPL insurer of the Harvard medical institutions

How much data?

Total Cases (Claims & Suits) • claims & suits • open & closed cases	~ 475,000+*
New cases annually	~ 12-15,000

Hospitals & Health Systems • Academic & Community	~ 550+ 20 AMCs
Physicians	200,000+

*Represents ~33% of US Claims



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National Data Collaborative

Academic Medical Centers

- **CRICO** (Harvard Medical affiliates) e.g.
  - Mass General, Brigham & Women's, Beth Israel Lahey Health, Boston Children's, Dana Farber
- **Cooper Health System** (NJ)
- **Healthcare Risk Advisors** (FKA: FOJP, NY)
  - Mount Sinai, Maimonides, Montefiore
- **Maine Medical Center**
- **Medstar**
  - Georgetown University, Washington Hospital
- **Michigan Medicine**
- **Temple University**
- **University of CA**
  - UCLA, UCSF, UC-Davis, UC-Irvine, UCSD
- **University of Florida / Shands**
  - Gainesville, Jacksonville
- **University of Maryland**
- **University of Massachusetts Memorial Health Care**
- **University of New Mexico**

Commercial & Captive Insurers

- **Cassatt RRG** (PA)
- **Constellation / MMIC Group**
- **The Doctors Company**
- **MedPro Group** (MedPro, Princeton)
- **Medical Insurance Exchange of CA** (MIEC)
- **MLMIC** (NY)
- **PRI** (NY)
- **SIMED** (PR)

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How claims data can tell the story

Major Allegation

based on complaint, 1:1 ratio

- **Diagnosis-related events**
- Surgical events
- Medical treatment events
- Obstetrical events
- Safety & security events

WHAT *(is alleged to have) happened e.g.*

- **failures of assessment, test ordering, follow up**
- **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)**

Responsible Service

1 primary + secondary

- **Primary / secondary**
- All providers in a specialty
  - CRNA in Anesthesiology
  - NP in OB

WHO *was the provider/service(s) involved e.g.*

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

Contributing Factors

RN review, multiple per case

- Clinical judgment
- Communication
- Supervision
- Technical skill
- Behavioral Issues

WHY it (*might have*) happened e.g.

- **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**

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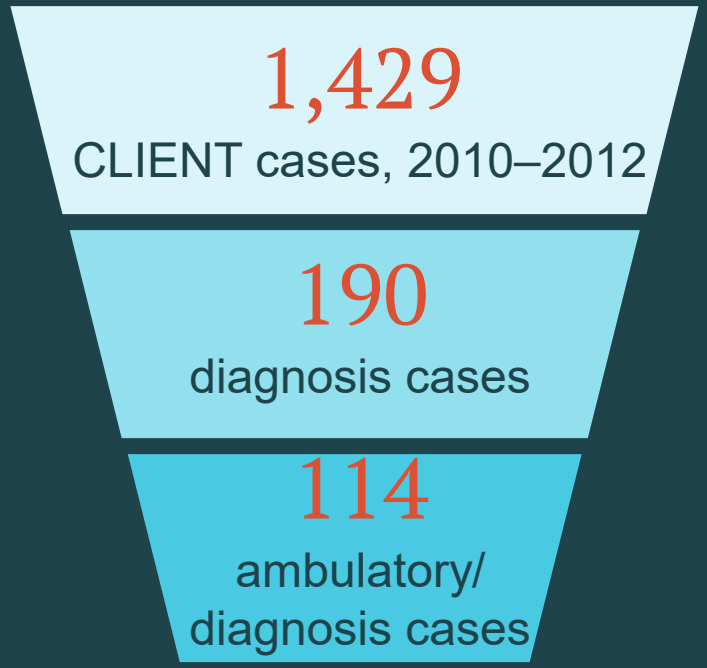
Overview

CLIENT PL claims (cases) asserted 2010 - 2012

1. **All CLIENT Cases**
   includes all services and allegations
   1,429 cases | $157M total incurred* losses

2. **Diagnosis-related Cases**
   cases with a diagnosis-related major allegation

3. **Ambulatory-based Diagnosis-related Cases**
   diagnosis cases involving outpatients and excluding ED locations



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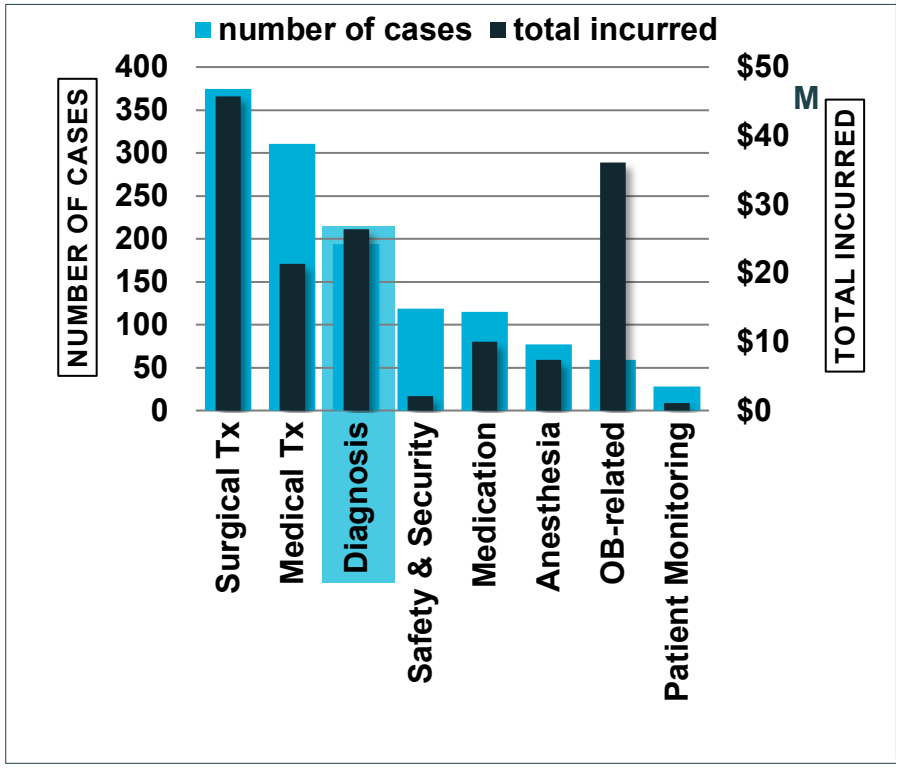
CLIENT's overall distribution of claim allegations is similar to Candello Database: Top Allegations

CLIENT - 1,429 cases



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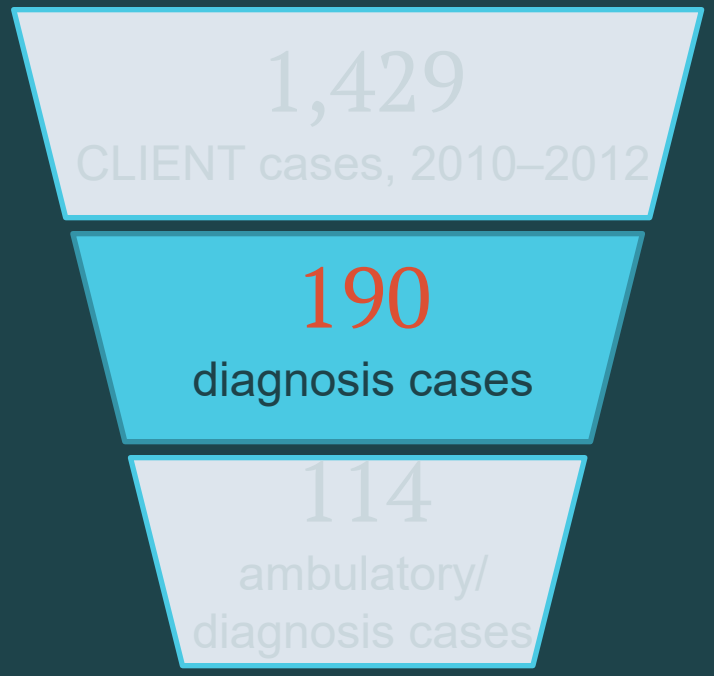
CLIENT N=1,429 PL cases asserted 1/1/10–12/31/12. - Peers N=8,986 PL cases asserted 1/1/10–12/31/12.

Diagnosis-related Cases

190 cases | $26M total incurred losses | asserted 2010–2012

Peer group: All Candello, excluding academic and teaching hospitals



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The 190 Dx-related cases asserted between 2010-2012 *occurred* (event date) between 2004-2012

Distribution of CLIENT diagnostic-related cases by Loss Year

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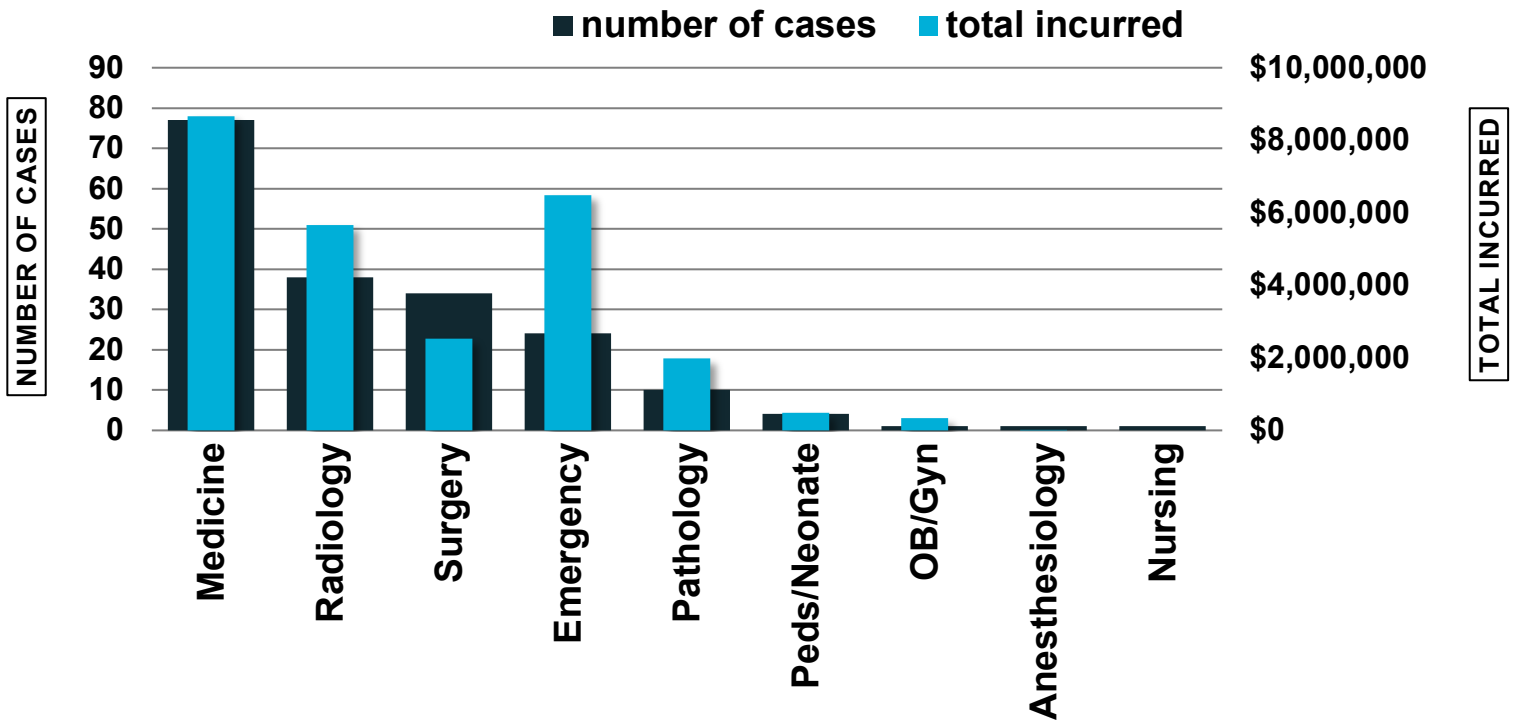
CLIENT N=190 PL cases asserted 1/1/10–12/31/12 with a diagnosis-related major allegation.

Medicine, Radiology, and Surgical Services are most frequently identified in Dx-related cases

Top Responsible Services in cases with a Diagnostic allegation



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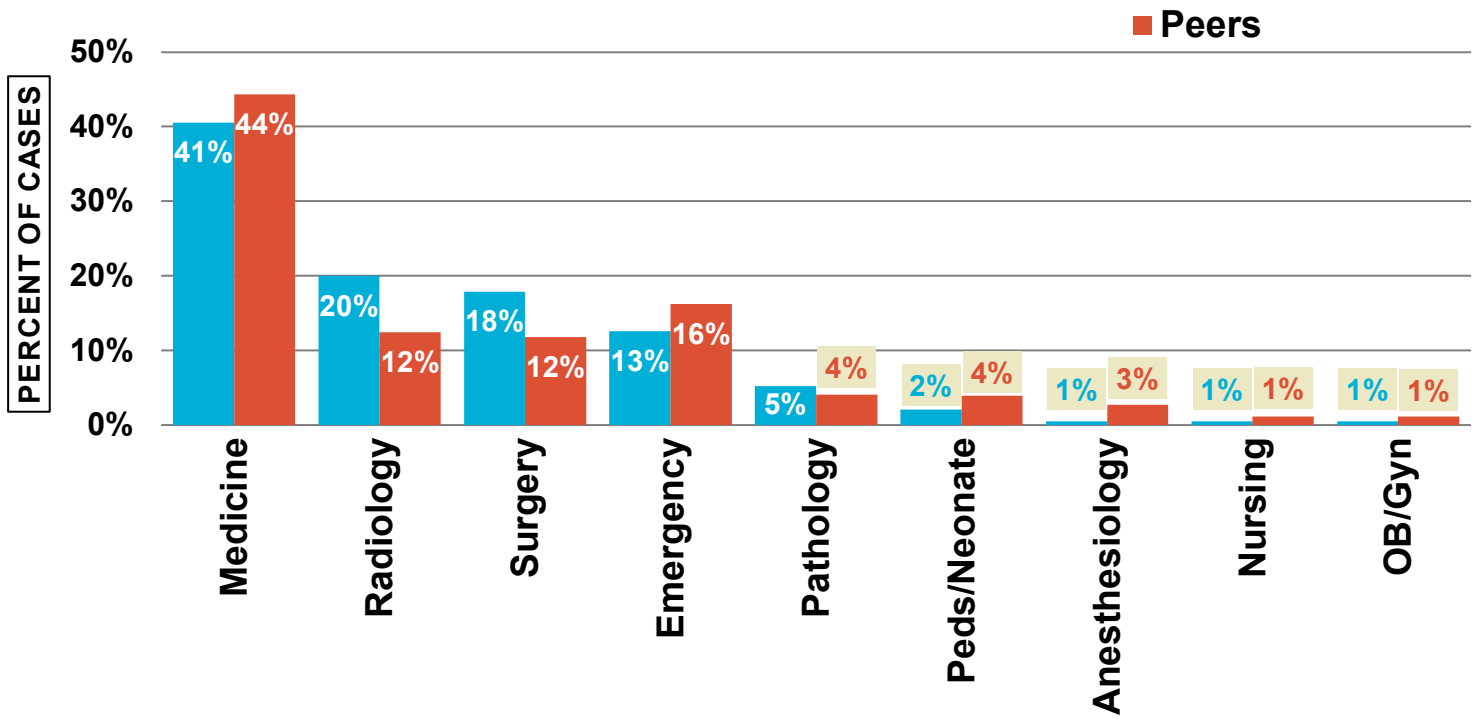
Surgery includes General Surgery and Surgery Subspecialties. - Medicine includes General Medicine and Medicine Subspecialties.

While %'s vary, CLIENT's top services in Dx-related cases are consistent with Candello peers

Top Responsible Services: Peer Comparison



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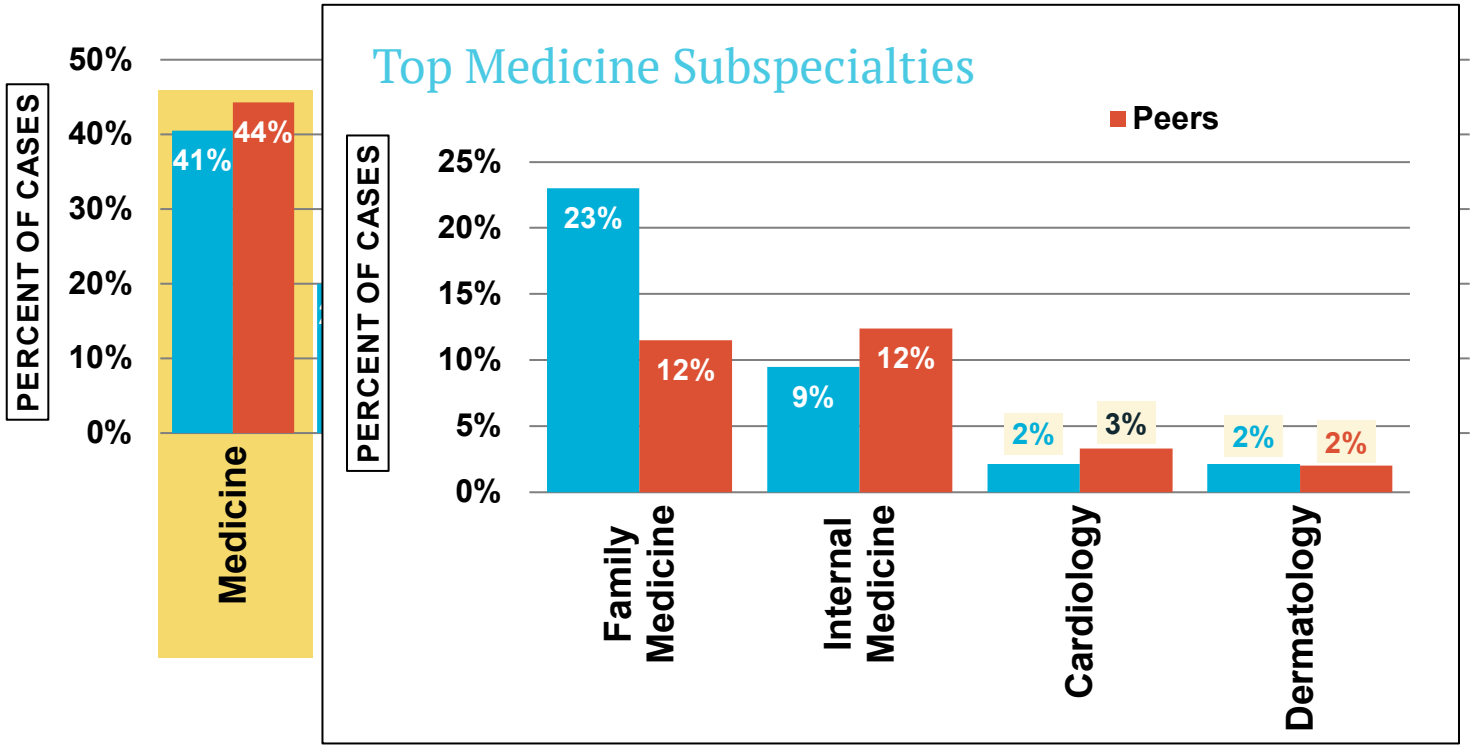
CLIENT N=190 PL cases asserted 1/1/10–12/31/12 with a diagnosis-related major allegation.
Peers N=1,842 PL cases asserted 1/1/10–12/31/12 with a diagnosis-related major allegation.

For CLIENT Medicine cases, Family Medicine is a more significant contributor to Dx-related claims

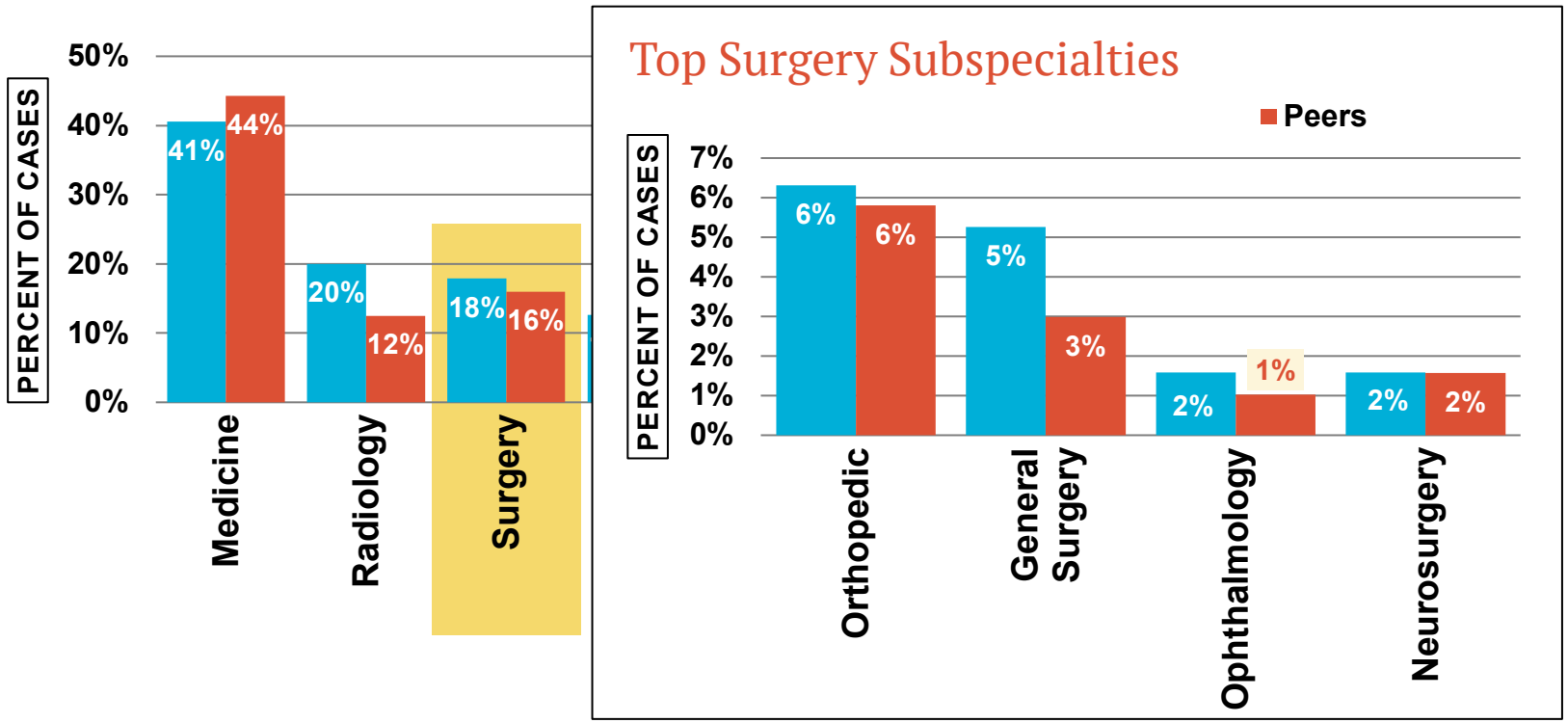
Top Responsible Services: Medicine - Peer Comparison



Peers N=1,842 PL cases asserted 1/1/10–12/31/12 with a diagnosis-related major allegation.

For CLIENT Surgical cases, the Surgical profile of Dx-related claims is more similar to Peers

Top Responsible Services: Surgery - Peer Comparison



Peers N=1,842 PL cases asserted 1/1/10–12/31/12 with a diagnosis-related major allegation.

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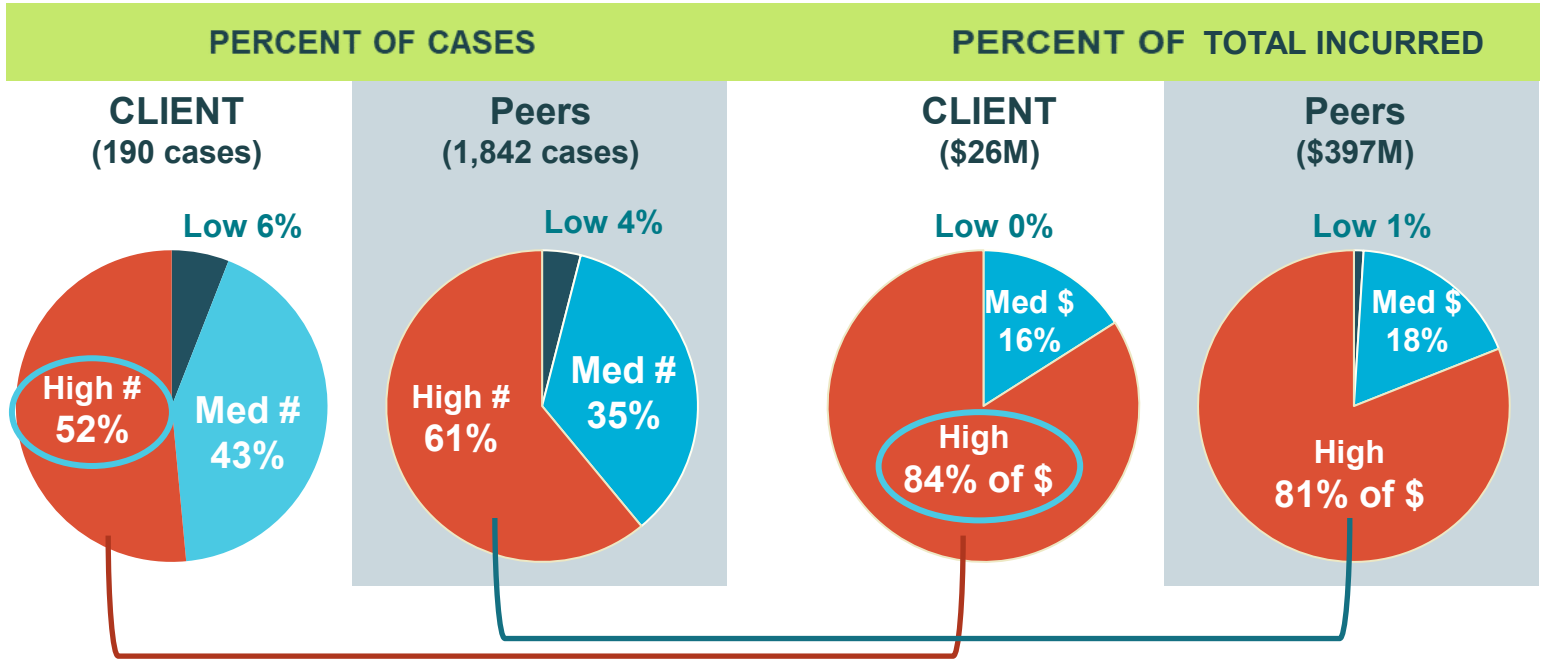
While CLIENT has lower proportion of high severity cases, the money spent on them is aligned with peers

Injury Severity: NAIC scale based on clinical severity



- Total Incurred includes reserves on open and payments on closed cases.
- Severity Scale: High=Death, Permanent Grave, Permanent Major, or Permanent Significant
  Medium=Permanent Minor, Temporary Major, or Temporary Minor
  Low= Temporary Insignificant, Emotional Only, or Legal Issue Only

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Like peers, the largest proportion of CLIENT's Dx-related cases occur in the ambulatory setting

Patient Type and Top Locations

PATIENT TYPE	CLIENT % OF CASES	PEERS % OF CASES
Inpatient	18%	28%
Ambulatory	60%	57%
ED	22%	15%

INPATIENT LOCATIONS (CLIENT)	# CASES	TOTAL INCURRED
Patient's room	12	$3,528,590
Radiology	7	$324,690
Operating room	5	$391,680
ICU (SICU, MICU, CCU)	5	$141,781
Pathology	2	$1,318,621

AMBULATORY LOCATIONS (CLIENT)	# CASES	TOTAL INCURRED
Hosp clinic/MD office	83	$8,014,944
Radiology	17	$2,644,425
Clinical laboratory	4	$545,773
Imaging	2	$218,602
Employee health clinic	2	$185,000
Satellite facilities	2	$95,481

Top Ambulatory Responsible Services	Count	Total Incurred
family medicine	32	$4,630,083
internal medicine	12	$1,412,696
orthopedic	9	$339,470
general surgery	4	$339,330
dermatology	4	$25,260

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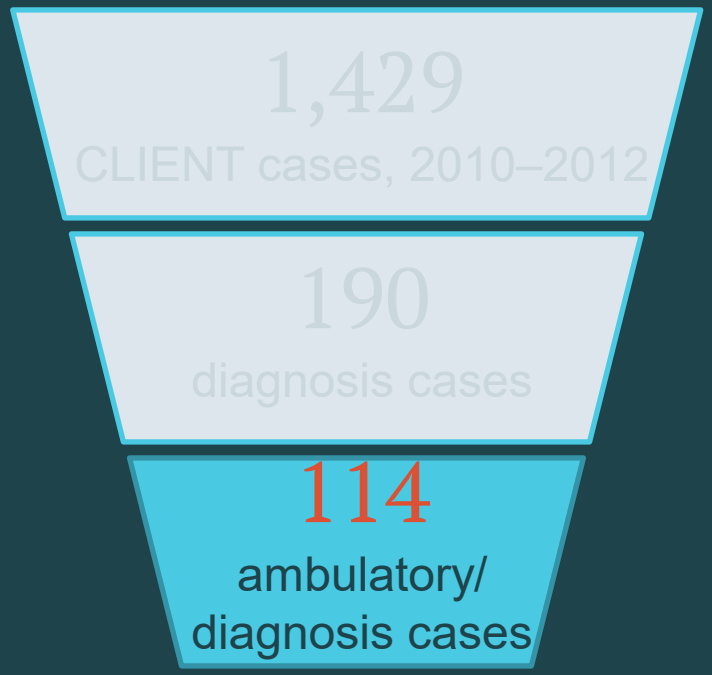
Diagnosis-related Cases in the Ambulatory Setting

114 cases | $12M total incurred losses | asserted 2010–2012

Peer group: All Candello ambulatory-based cases, excluding academic and teaching hospitals



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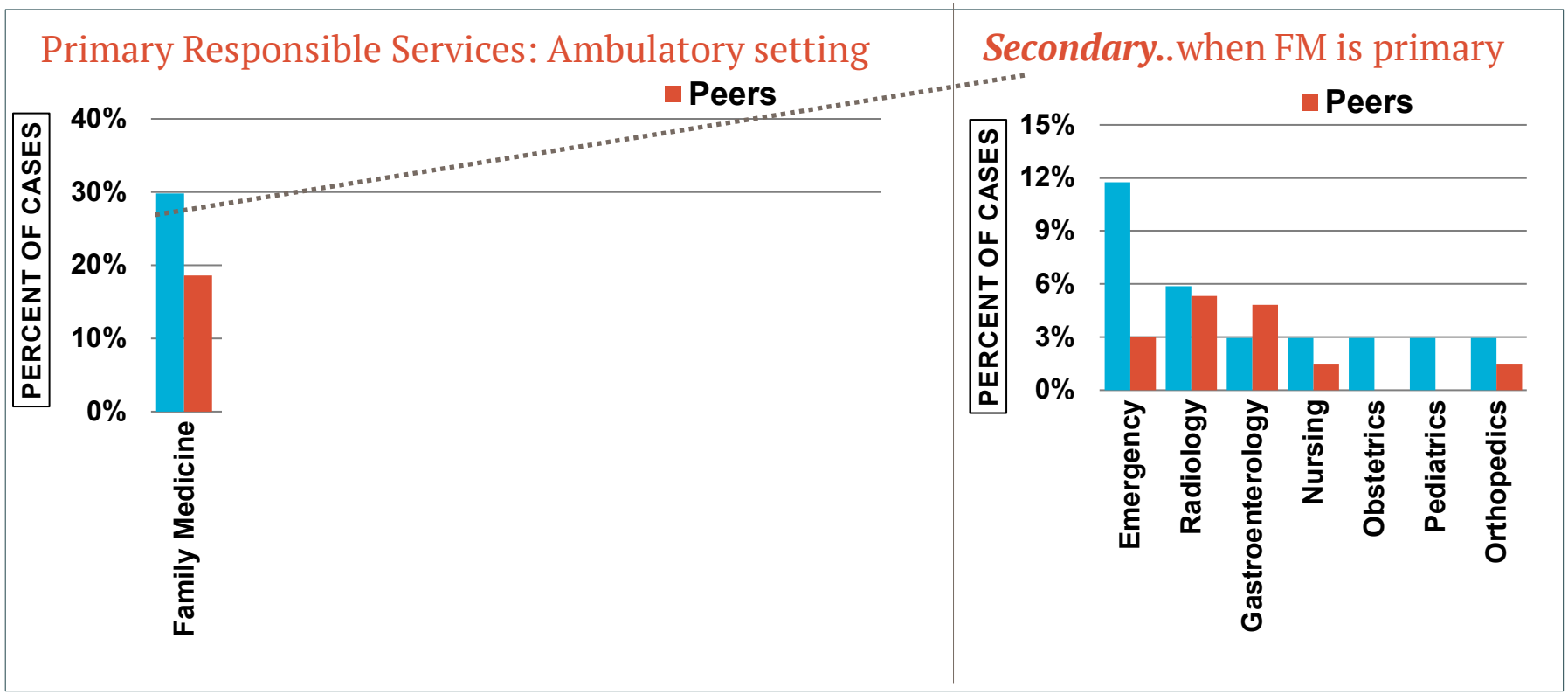
Family Medicine and Radiology are the top services in ambulatory Dx-related claims

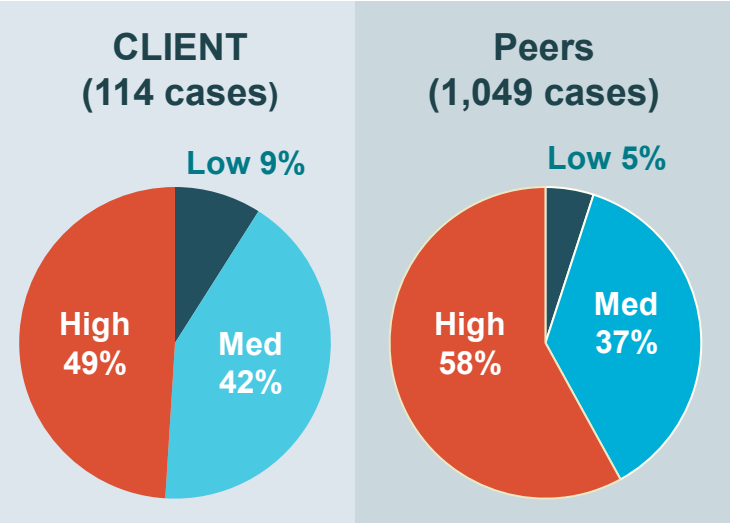
Top Primary Responsible Services for Ambulatory cases



CLIENT N=114 | Peers N=1,049
PL cases asserted 1/1/10–12/31/12 with a diagnosis-related major allegation, involving an outpatient, and excluding ED locations.

While the proportion of high severity injuries is similar, the types of injuries/final diagnoses in CLIENT's cases differs from peers

Clinical Severity and Final Diagnosis



FINAL DIAGNOSIS	CLIENT % CASES	PEERS % CASES
Cancer	31%	46%
Cardiac disease	11%	6%
Fractures & dislocations	10%	4%

CLIENT N=114 | Peers N=1,049
PL cases asserted 1/1/10–12/31/12 with a diagnosis-related major allegation, involving an outpatient, and excluding ED locations.

Severity Scale:

High=Death, Permanent Grave, Permanent Major, or Permanent Significant
Medium=Permanent Minor, Temporary Major, or Temporary Minor
Low= Temporary Insignificant, Emotional Only, or Legal Issue Only

Top Contributing Factors

FACTOR	CLIENT	PEERS
Clinical Judgment	93%	77%
Communication	22%	27%
Behavior-related	19%	31%
Clinical Systems	12%	16%
Documentation	12%	18%
Administrative	10%	9%

TOP CLINICAL JUDGMENT FACTORS	CLIENT	PEERS
Failure/delay in ordering Dx test	43%	35%
Misinterpretation of Dx studies (X-rays, slides, films)	35%	24%
Failure to respond to repeated patient's concerns or ongoing symptoms	18%	6%
Failure/delay in obtaining consult / referral	24%	15%
Lack of/inadequate history & physical (including allergies)	9%	8%

TOP COMMUNICATION FACTORS	CLIENT	PEERS
Communication—patient/family & provide	11%	4%
Communication among providers—failure to read medical record	9%	3%
Communication among providers—regarding patient's condition	6%	9%

TOP BEHAVIORAL FACTORS	CLIENT	PEERS
Patient factors—noncompliance with follow-up call/appointment	5%	11%
Patient factors—noncompliance with treatment regimen	3%	9%

*A case will often have multiple factors identified thus appearing in more than one category.

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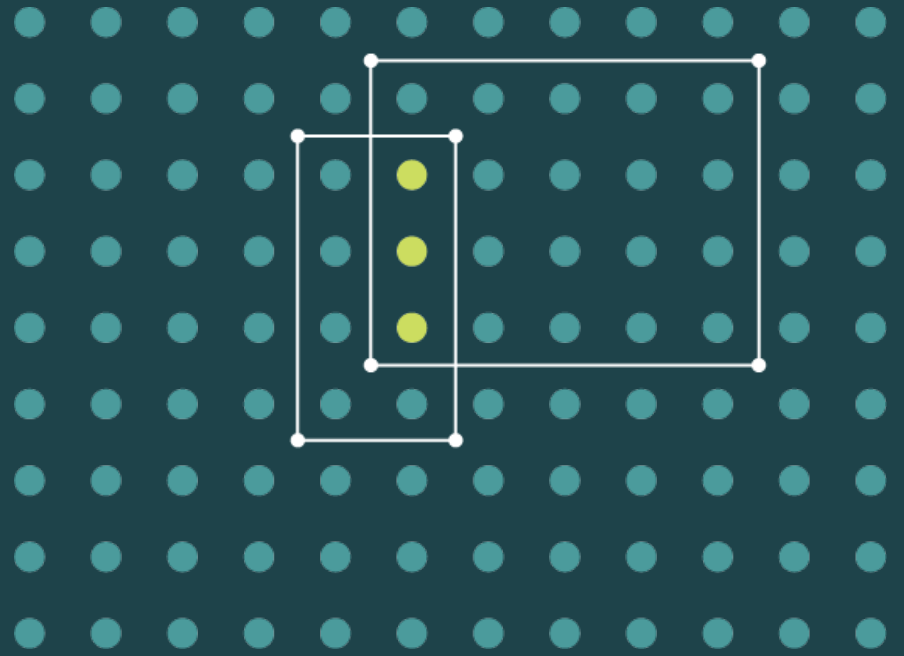

Summary & Recommendations

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Summary of data findings

While the high level profile of Dx-related cases is similar to peers (distribution by % and location (ambulatory), the case type and underlying issues are different

- Larger proportion of Family Medicine cases (23% vs. 12%)
- Fewer High Severity cases but same cost as peer's high severity
- Different case type profile:
  - heart attacks and fractures vs. cancer
- More Clinical Judgment issues
  - ordering tests and consult
  - test interpretation – radiology
- Fewer communication and compliance issues

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Summary of case review

A key trend noted in CLIENT's Dx-related cases is a "less than aggressive" pursuit of short term / urgent presentations

- Failure to respond to repeated complaints (multiple visits w/out escalation)
- Failure to generate a broader differential diagnose (documentation / testing)
- Failure to obtain tests (e.g. scans and cardiac work-ups)
- Failure to consult or refer (even in multiple visits for repeated complaints)
- Misinterpretation of Dx studies (impact of APCs and MDs reading own films)
- Lax use of "protocols" (referrals, cardiac w/ups, orthopedics, radiology (OB))

Discussion: Potential barriers to a comprehensive diagnostic process

Explore patient / provider geographical barriers to comprehensive Dx process

- Familiarity / longevity with patients
- Complacency / acceptance of “what always is”
- Limited exposure to difficult / veiled presentations
- Lack of diagnostic curiosity (if remote, no peers to “challenge”)
- Geographical challenges (burden to consultation / testing)
- (Over)confidence (comfort w/ Derm, reading own films)
- Breadth of practice (FP) too broad (OB, GYN, Pedi)
- No structure for formal “teaming”
- Financial (payor) issues

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Discussion: Potential Solutions

Create an integrated diagnostic community for the remote, small practice and/or isolated practitioner

- Video / Skype conferencing for clinical consults
- Telemedicine (remote radiology review)
- Consult resources (consult pools / partnerships / MD Connect)
- Protected “discussion sites” for ongoing dialogue / reading groups
- Clinical Guidelines (embedded in EMR)
- Management Guidelines (for APCs)
- Targeted CME to known risk area (Cardiac, GYN)
- Diagnostic tools (examples: Isabel, Visual Dx)

Next steps

Creating focus on and investment in improving the diagnostic process

- Share the data analyses – feedback, validation, buy-in
- Review case studies (additional teaching abstracts on CRICO site)
- Educational forums: Ambulatory M&M, Grand Rounds
- Culture of Safety survey
- Physician Office / Practice evaluations
- Proactive Peer Review (trends and triggers)
- CLIENT based support / collaboration / convening
    - Ambulatory Risk Managers

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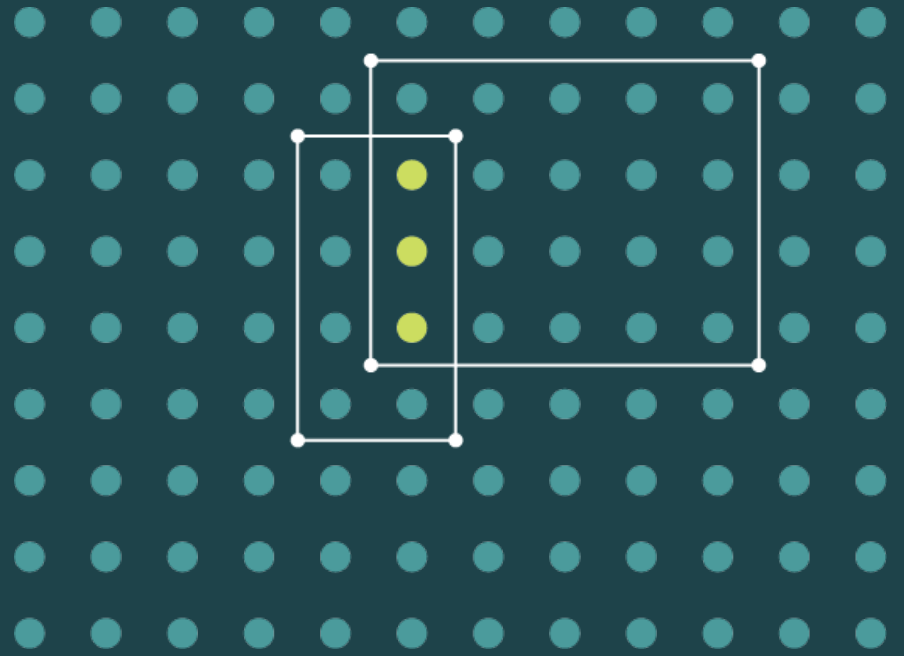

Questions?

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