Montefiore

System Quality Control and Malpractice Costs

Peter Shamamian, MD FACS
Vice President and Chief Quality Officer
Vice Chairman for Quality and Performance Improvement

Disclosures

Montefiore

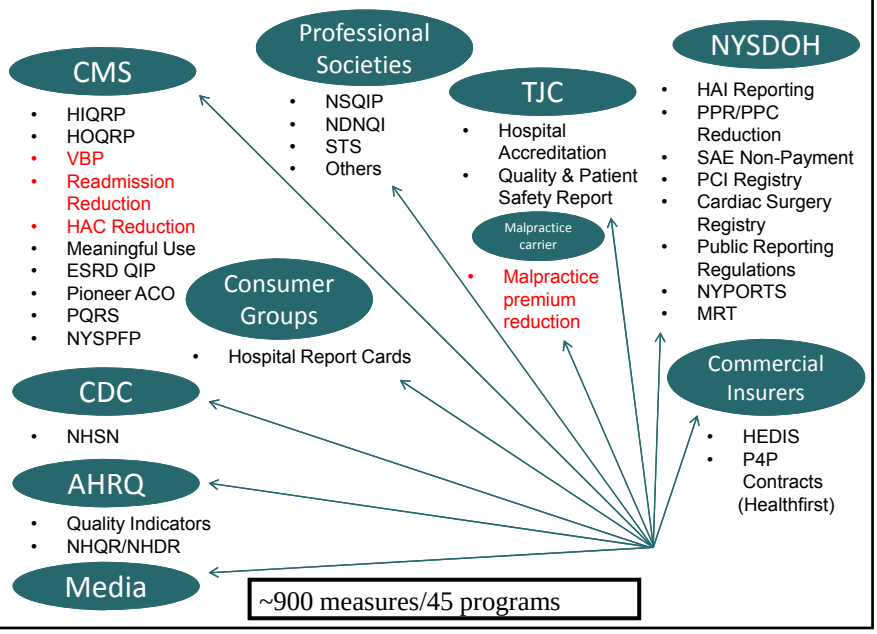
"The world of healthcare is changing. The idea of the solo doctor with his or her pen doing whatever they want and getting paid whatever they charge, those days are gone. There is much more regulation much more oversight. There is much more concept of being paid for quality and meeting certain benchmarks and targets as apposed for being paid for just what you do."

Dr. Michael Stewart Vice Dean of **Weill Cornell** Medical College and Chairman of Otolaryngology

https://www.wnyc.org/radio/#/ondemand/398927
WNYC The Takeaway Job Fair: Paging Young Doctors, Monday September 8th 2014

Montefiore

Consumers of Quality Measurement Data



WHO USES HOSPITALS PUBLICLY REPORTED QUALITY DATA?

npr shots

your health treatments & tests health inc. policy·ish public health

treatments

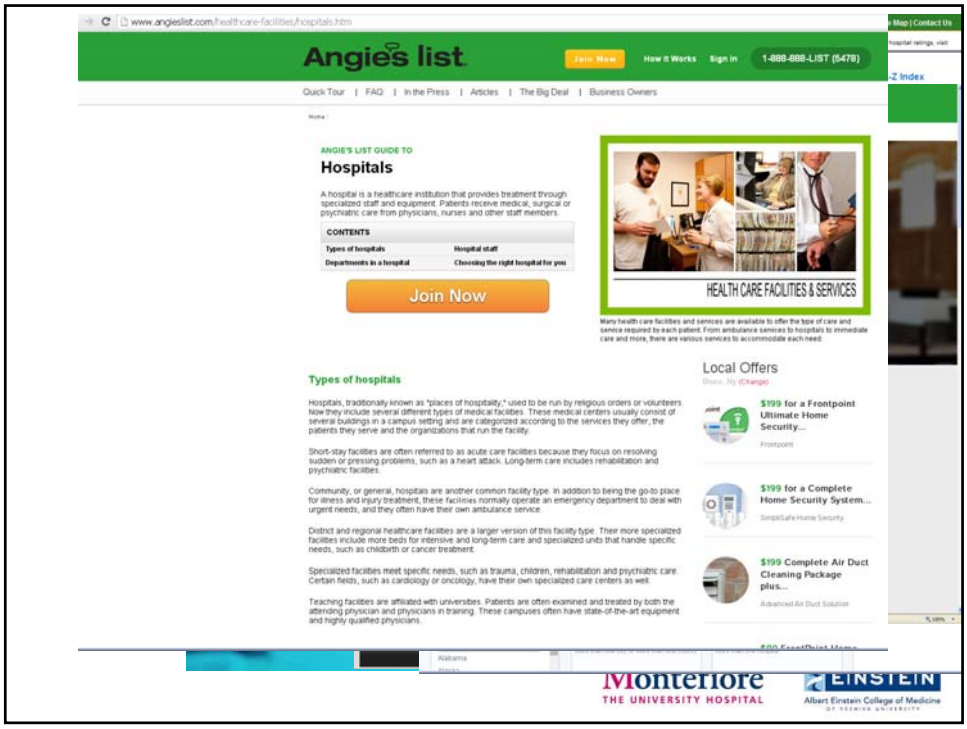
How Many Die From Medical Mistakes In U.S. Hospitals?

September 20, 2013 4:52 PM ET

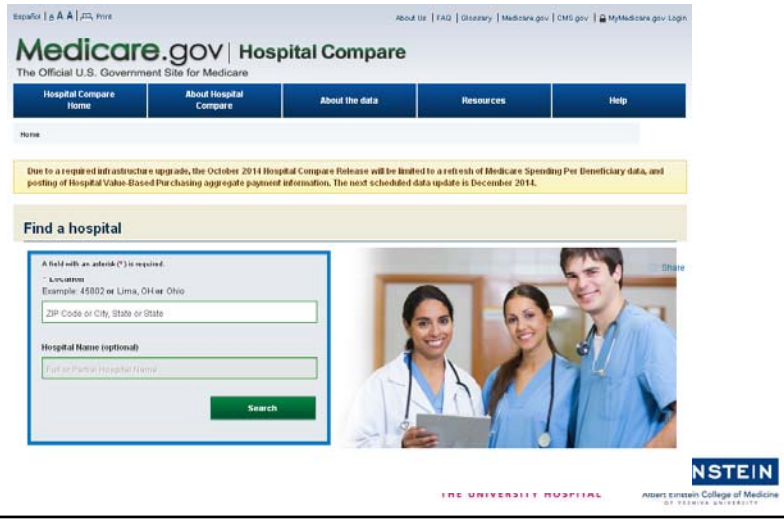
MARSHALL ALLEN, PROPUBLICA

Montefiore THE UNIVERSITY HOSPITAL

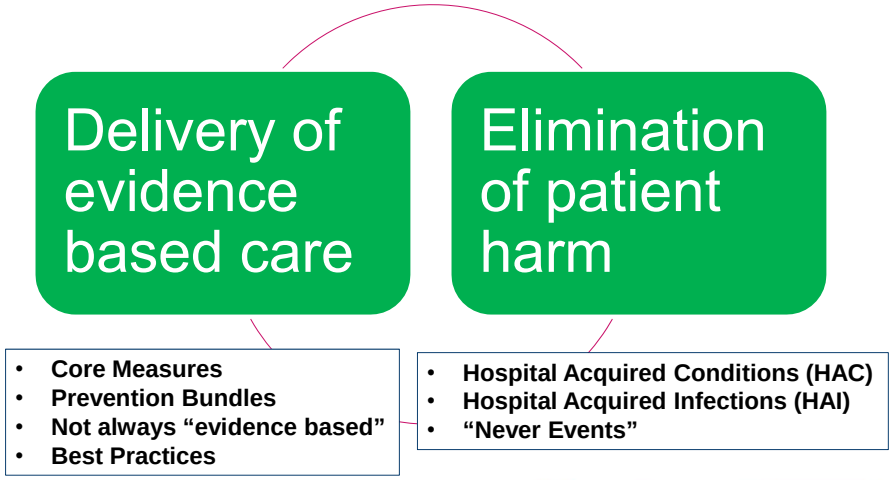
EINSTEIN Albert Einstein College of Medicine



Where Do You Find Data on Hospital Performance?



Guiding Principles of Quality Initiatives



Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

CMS Payment Reduction Programs

Value-Based Purchasing (VBP-Core Measures)

- Incentive program that reduces payments based on performance measures
- Process of care, Patient experience, Outcomes, Efficiency

Hospital Acquired Condition (HAC) Reduction Program

- Penalty Program that Reduces Payments to Hospitals for Excess HACs

Readmission (Unplanned) Reduction Program

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

VBP-Clinical Process or Core Measure

AMI	Aspirin prescribed at discharge
	Fibrinolytic agent received within 30 minutes of arrival
	Primary percutaneous intervention (PCI) within 90 minutes of arrival
HF	Discharge instructions
	Evaluation of left ventricular systolic function
	ACE-I or ARB for left ventricular systolic dysfunction
Pneu	Blood culture performed in the ED before first antibiotic
	Appropriate antibiotic selection for CAP
SCIP	**Venous thromboembolism (VTE) prophylaxis within 24 hrs of surgery**
	Prophylactic antibiotic within one hour prior to surgery
	Prophylactic antibiotic selection for surgical patients
	Prophylactic antibiotic discontinued within 24 hours (48 hrs for CTS)
	Cardiac surgery patients with 6 AM controlled glucose (PO day 1 & 2)
	Urinary catheter removed on post-op day 1 or 2
	Surgery patients who received beta blockers perioperatively

Montefiore

VBP-Patient Experience

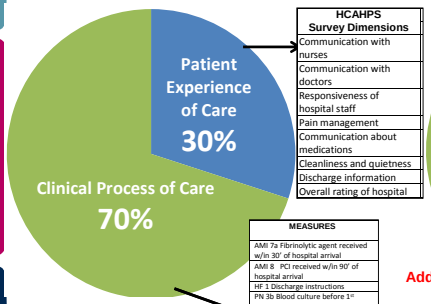
Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS)

HCAHPS Survey Dimensions
Communication with nurses
Communication with doctors
Responsiveness of hospital staff
Pain management
Communication about medications
Cleanliness and quietness
Discharge information
Overall rating of hospital

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

CMS Value-Based Purchasing (VBP)

FY 2013
Payments 10/1/12-9/30/13

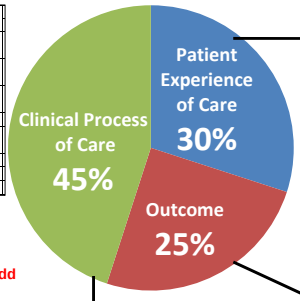


HCAHPS Survey Dimensions
Communication with nurses
Communication with doctors
Responsiveness of hospital staff
Pain management
Communication about medications
Cleanliness and quietness
Discharge information
Overall rating of hospital

MEASURES
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival
AMI 8 PCI received w/in 90' of hospital arrival
HF 1 Discharge instructions
PN 3b Blood culture before 1st antibiotic received in hospital
PN 6 Initial antibiotic selection for CAP immunocompetent pt
SCIP 1 Abx w/in 1 hr before incision or w/in2 hrs if Vancomycin/ Quinolone is used
SCIP 2 Received prophylactic Abx consistent with recommendations
SCIP 3 Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery
SCIP 4 Controlled 6 AM postoperative serum glucose – cardiac surgery
SCIP-VTE 1 Recommended VTE prophylaxis ordered during admission
SCIP VTE2 Received VTE prophylaxis w/in 24 hrs prior to or after surgery
SCIP-Card 2 Pre-admission beta-blocker and perioperative period beta blocker

SCIP

FY 2014
Payments 10/1/13-9/30/14



HCAHPS Survey Dimensions
Communication with nurses
Communication with doctors
Responsiveness of hospital staff
Pain management
Communication about medications
Cleanliness and quietness
Discharge information
Overall rating of hospital

Add

SCIP 9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2

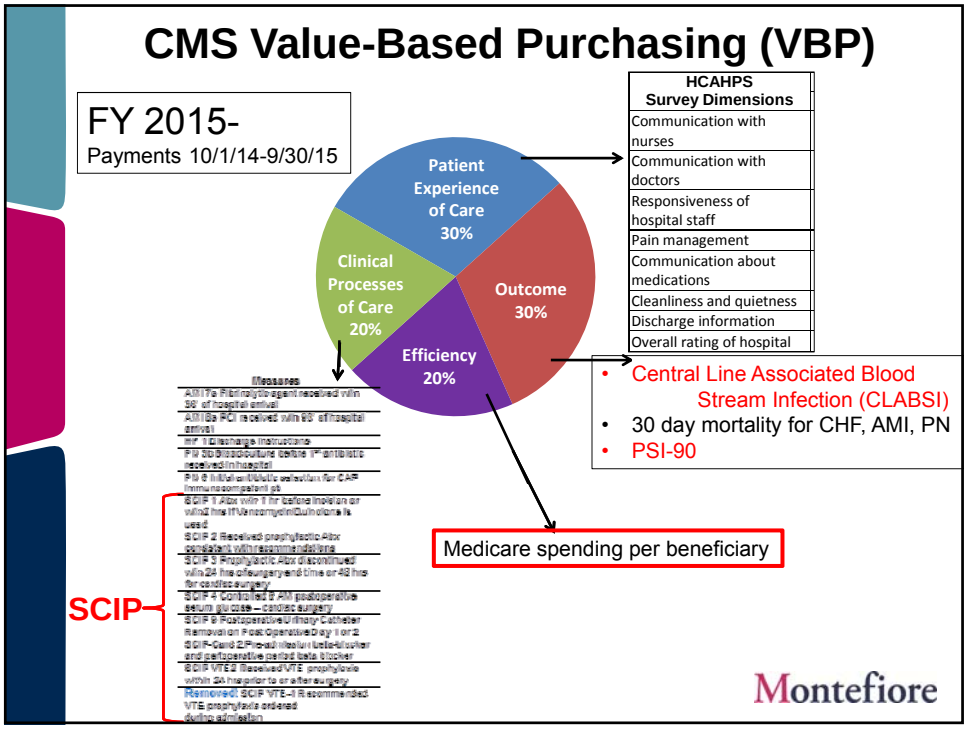
30 day mortality for CHF, AMI, PN

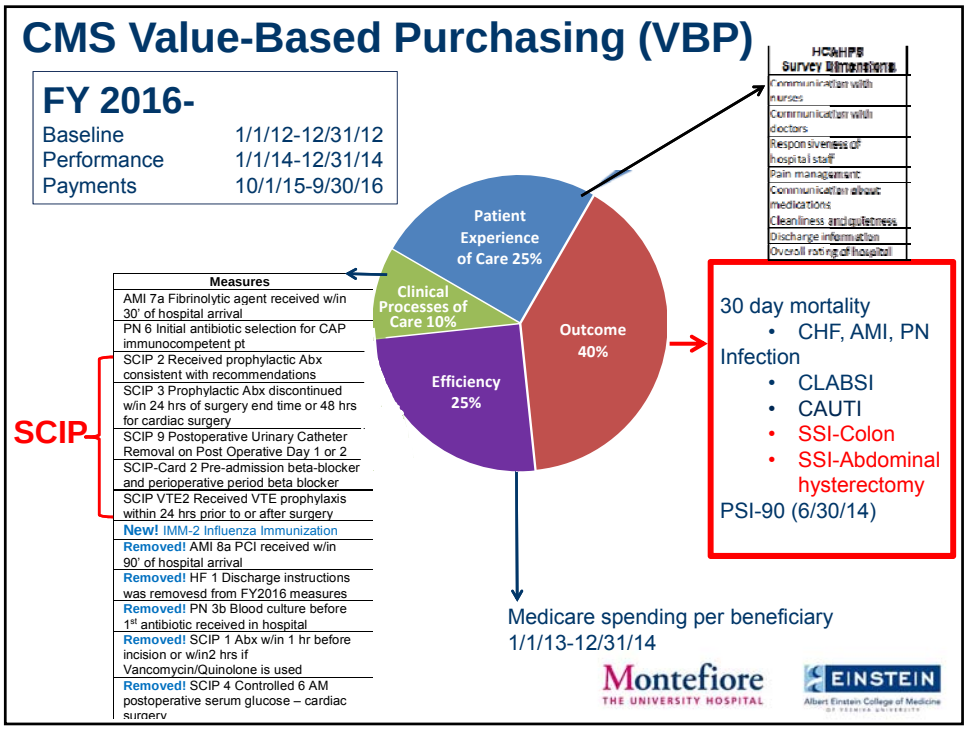
Montefiore

Agency for Health Care Research and Quality (AHRQ) Patient Safety Indicators (PSI-90) added in 2015

PSI-3: Pressure Ulcer rate - 2.4%
PSI-6: Iatrogenic pneumothorax rate – 7.1%
PSI-7: CLABSI– 6.5%
PSI-8: Post operative hip fracture rate – 0.1%
PSI-12: Perioperative PE/DVT rate – 25.8%
PSI-13: Post Operative sepsis rate - 7.4%
PSI-14: Wound dehiscence rate - 1.7%
PSI-15: Accidental puncture and laceration – 49.2%

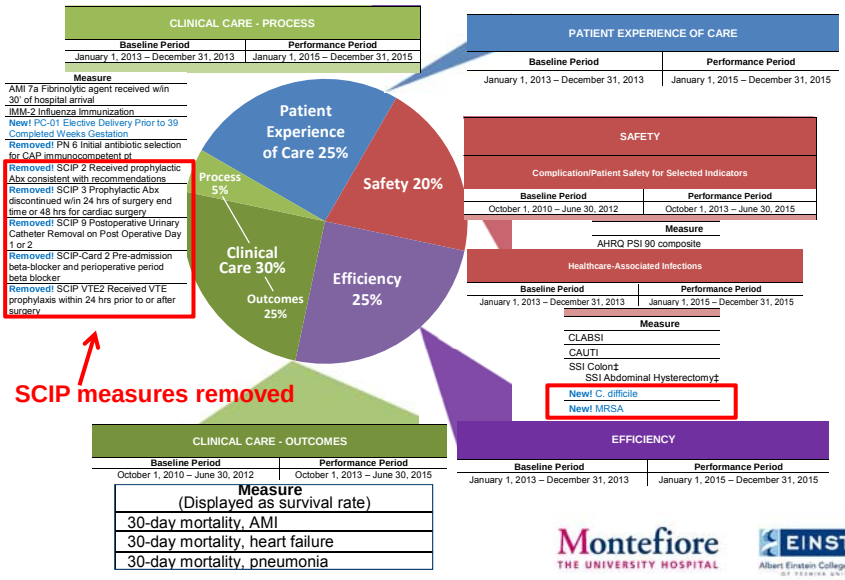
Montefiore


CMS Value-Based Purchasing (VBP)
FY 2015-
Payments 10/1/14-9/30/15
Patient Experience of Care 30%
Outcome 30%
Efficiency 20%
Clinical Processes of Care 20%
HCAHPS Survey Dimensions
Communication with nurses
Communication with doctors
Responsiveness of hospital staff
Pain management
Communication about medications
Cleanliness and quietness
Discharge information
Overall rating of hospital
Central Line Associated Blood Stream Infection (CLABSI)
30 day mortality for CHF, AMI, PN
PSI-90
Medicare spending per beneficiary
SCIP
Montefiore


CMS Value-Based Purchasing (VBP)
FY 2016-
Baseline 1/1/12-12/31/12
Performance 1/1/14-12/31/14
Payments 10/1/15-9/30/16
Patient Experience of Care 25%
Outcome 40%
Efficiency 25%
Clinical Processes of Care 10%
HCAHPS Survey Dimensions
Communication with nurses
Communication with doctors
Responsiveness of hospital staff
Pain management
Communication about medications
Cleanliness and quietness
Discharge information
Overall rating of hospital
Measures
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival
PN 6 Initial antibiotic selection for CAP immunocompetent pt
SCIP 2 Received prophylactic Abx consistent with recommendations
SCIP 3 Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery
SCIP 9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
SCIP-Card 2 Pre-admission beta-blocker and perioperative period beta blocker
SCIP VTE2 Received VTE prophylaxis within 24 hrs prior to or after surgery
New! IMM-2 Influenza Immunization
Removed! AMI 8a PCI received w/in 90' of hospital arrival
Removed! HF 1 Discharge instructions was removesd from FY2016 measures
Removed! PN 3b Blood culture before 1st antibiotic received in hospital
Removed! SCIP 1 Abx w/in 1 hr before incision or w/in2 hrs if Vancomycin/Quinolone is used
Removed! SCIP 4 Controlled 6 AM postoperative serum glucose – cardiac surgery
SCIP
30 day mortality
CHF, AMI, PN
Infection
CLABSI
CAUTI
SSI-Colon
SSI-Abdominal hysterectomy
PSI-90 (6/30/14)
Medicare spending per beneficiary 1/1/13-12/31/14
Montefiore THE UNIVERSITY HOSPITAL
EINSTEIN Albert Einstein College of Medicine

CMS Value-Based Purchasing (VBP)

FY 2017- Payments 10/1/16-9/30/17



CLINICAL CARE - PROCESS

Baseline Period	Performance Period
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015

Measure
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival
IMM-2 Influenza Immunization
New! PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation
Removed! PN 6 Initial antibiotic selection for CAP immunocompetent pt
Removed! SCIP 2 Received prophylactic Abx consistent with recommendations
Removed! SCIP 3 Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery
Removed! SCIP 9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
Removed! SCIP-Card 2 Pre-admission beta-blocker and perioperative period beta blocker
Removed! SCIP VTE2 Received VTE prophylaxis within 24 hrs prior to or after surgery

SCIP measures removed

PATIENT EXPERIENCE OF CARE

Baseline Period	Performance Period
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015

SAFETY

Complication/Patient Safety for Selected Indicators

Baseline Period	Performance Period
October 1, 2010 – June 30, 2012	October 1, 2013 – June 30, 2015

Measure
AHRQ PSI 90 composite

Healthcare-Associated Infections

Baseline Period	Performance Period
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015

Measure
CLABSI
CAUTI
SSI Colon‡
SSI Abdominal Hysterectomy‡
New! C. difficile
New! MRSA

EFFICIENCY

Baseline Period	Performance Period
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015

CLINICAL CARE - OUTCOMES

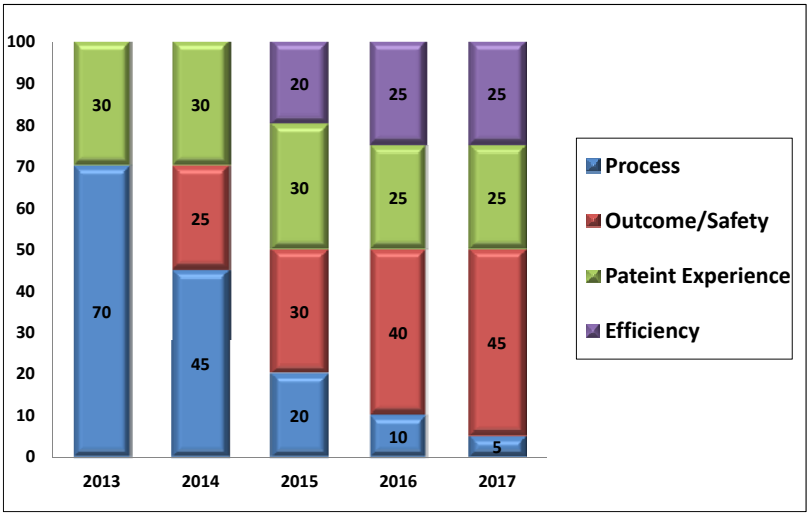
Baseline Period	Performance Period
October 1, 2010 – June 30, 2012	October 1, 2013 – June 30, 2015

Measure (Displayed as survival rate)
30-day mortality, AMI
30-day mortality, heart failure
30-day mortality, pneumonia

Montefiore THE UNIVERSITY HOSPITAL

EINSTEIN Albert Einstein College of Medicine

Changes in VBP Indicator Weighting: from Process to Outcome



Montefiore

Hospital Acquired Conditions (HAC)

- Defined by Deficit Reduction Act (2005):
  - high cost (or high prevalence)
  - result in higher DRG coding
  - are potentially preventable
- The ACA mandated a 1% Medicare reimbursement penalty for hospitals in the bottom 25%'ile for HACS

Montefiore

HAC Reduction Program Framework 2016

Domain 1
(AHRQ Measure)

Weighted 25%

AHRQ PSI-90 Composite

This measure consists of performance period from July 1, 2012 – June 30, 2014:

PSI-3: pressure Ulcer rate - 2.4%
PSI-6: Iatrogenic pneumothorax rate – 7.1%
PSI-7: CLABSI– 6.5%
PSI-8: Post operative hip fracture rate – 0.1%
PSI-12: Perioperative PE/DVT rate – 25.8%
PSI-13: Post Operative sepsis rate - 7.4%
PSI-14: wound dehiscence rate - 1.7%
PSI-15: accidental puncture and laceration – 49.2%

Domain 2
(CDC Measures)

Weighted 75%

2016 (performance period CY 2013-2014):
CAUTI
CLABSI
Surgical Site Infection
Colon Surgery
Abdominal Hysterectomy

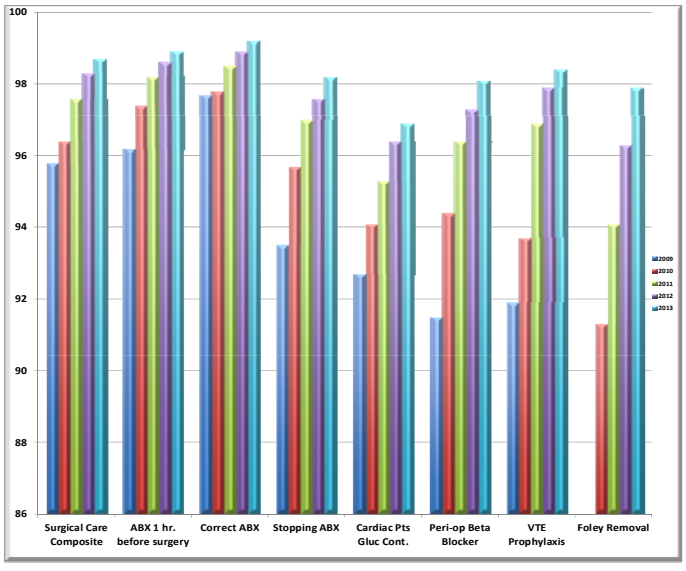
Montefiore

Do Physicians Adhere to Quality Standards?

Montefiore THE UNIVERSITY HOSPITAL

EINSTEIN Albert Einstein College of Medicine

Improvement on National Surgical Care Improvement Project (SCIP) Measures Rates (2009-2013)

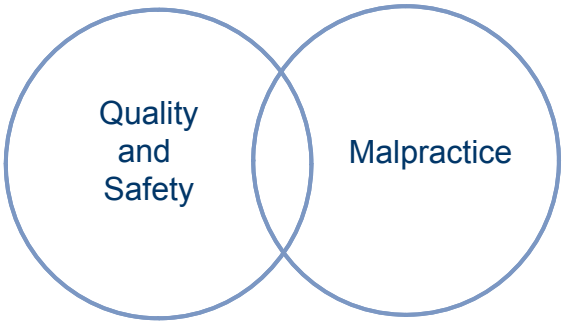


Does Adherence to Process Measures Improve Outcomes?

- Conflicting data-depends on measure and outcome
- Antibiotics are necessary in reducing SSI but other factors contribute
- β-blockers may be helpful or harmful
- VTE prophylaxis guidelines vary by specialty
- Documentation is vital to demonstrate clinical judgment and also helps with malpractice cases
- With the shift of emphasis on outcomes to be successful hospitals must have reliable processes

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Is There an Overlap Between Quality of Care Delivered and Malpractice?



Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Intent of Malpractice- Deterrence

Assumptions

- Threat of malpractice deters poor care
- Improves adherence to standards

Unintended consequences

- Defensive medicine
- Overuse of services
- Over testing
- Overtreatment
- More risk to patients
- Similar to process measures?

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

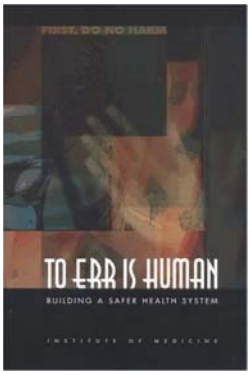
Impact of Medical Malpractice Environment on Surgical Quality and Outcomes

"Though there is evidence that medical malpractice liability influences physicians' clinical choices, there is little to support the theory that the threat of medical litigation improves physician adherence to quality care indicators or improves patient outcomes."

JACS Vol. 218 No. 2 Feb. 2014

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

1999 IOM Report-To Err is Human



- 1999 IOM Report- To Err is Human 44,000 to 98,000 deaths a year from medical errors
- 2013 report in the Journal of Patient Safety estimated 210,000-400,000 deaths were associated with preventable harm
- Only 2% of negligent care results in law suits

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Surgical Morbidity and Mortality

- Mortality rate for inpatient surgery is 0.4 to 0.8%.
- Rate of major complications is 3 to 17%.
- At least half of all surgical complications are avoidable.[1,2]

1. Thomas EJ, Zinner MJ, Brennan TA. The incidence and nature of surgical adverse events in Colorado and Utah in 1992. Surgery 1999;126:66-75.
2. Kable AK, Gibberd RW, Spigelman AD. Adverse events in surgical patients in Australia. Int J Qual Health Care 2002;14: 269-76.

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

National Overview of Malpractice

Data from a national liability insurer (1991-2005)

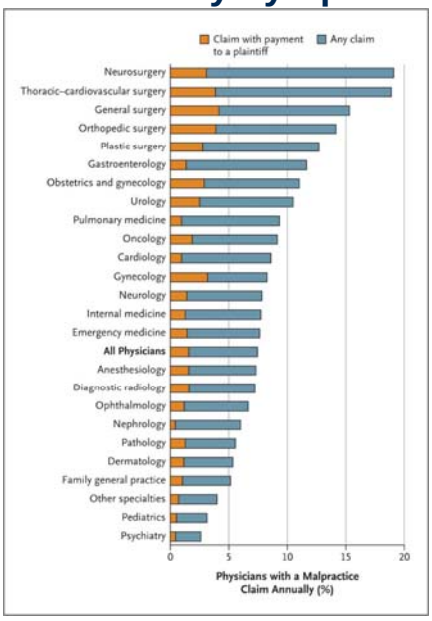
- Annual cost of medical malpractice $55 billion
- 78% of claims did not result in payments to claimants
- 7.4% of physicians faced a malpractice claim each year
  - 1.6% led to paid claim
- 75 to 99% of physicians will face a malpractice claim by the age of 65
- Factors that drive claims are independent of the size of pay-out

NEJM 365(7):629-636, 2011

Montefiore THE UNIVERSITY HOSPITAL

EINSTEIN Albert Einstein College of Medicine

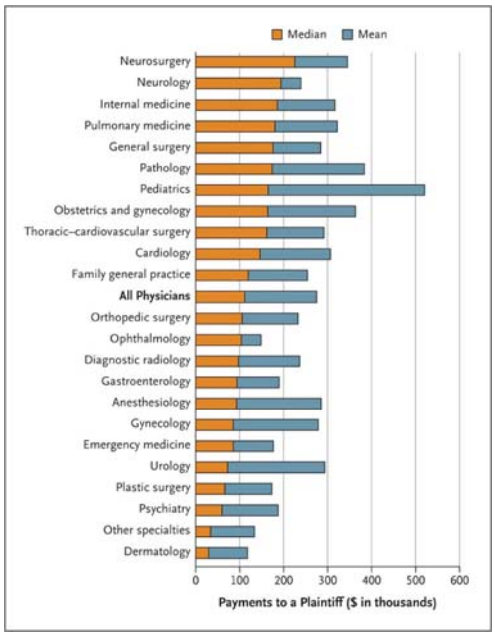
Proportion of Physicians Facing a Malpractice Claim Annually by Specialty



Jena AB et al. N Engl J Med 2011;365:629-636

Montefiore

Amount of Malpractice Payments by Specialty.



Jena AB et al. N Engl J Med 2011;365:629-636

Montefiore

Top 10 Claims for Surgery- Related Allegations National Practitioner Data Bank 1990-2011

Allegation	Total Paid Claims	Percent Taken to Court (%)
Improper Performance	10937	4
Improper Technique	2009	5
Failure to Recognize a Complication	1707	4
★ Retained Foreign Body	1266	4
Improper Management	1070	4
Unnecessary Procedure	819	5
★ Wrong Body Part	683	3
Failure to Obtain Consent/Lack of Informed Consent	615	8
Failure to Perform Procedure	468	5
Delay in Performance	299	5
Total	**19873**	

★ HAC/never events

JOURNAL OF HEALTHCARE RISK MANAGEMENT • VOLUME 33, NUMBER 4

Montefiore THE UNIVERSITY HOSPITAL

EINSTEIN Albert Einstein College of Medicine

Inflation-Adjusted Average Cash Payouts per Patient for the Top 10 Claims

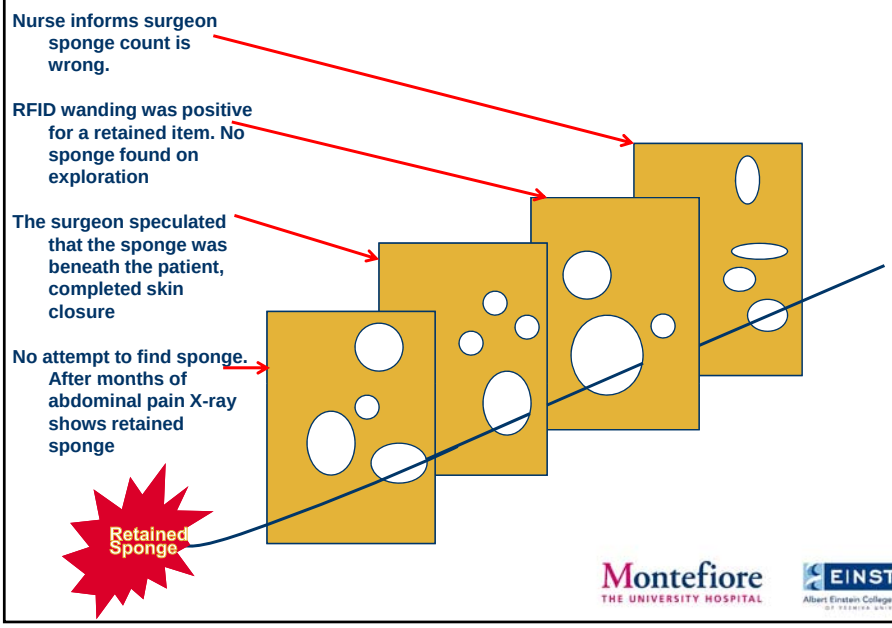
Freq.	Allegation	Payout per Patient ($)		
		Permanent Injury	Temporary Injury	Emotional Injury
10	Delay in Performance	427 428	198 578	18 603
1	Improper Performance	411 829	207 613	63 395
3	Failure to Recognize a Complication	409 713	215 232	40 955
2	Improper Technique	397 500	159 855	53 623
9	Failure to Perform Procedure	386 851	131 559	56 251
6	Unnecessary Procedure	366 431	181 081	87 472
5	Improper Management	352 627	199 737	98 948
8	Failure to Obtain Consent/Lack of Informed Consent	305 295	117 938	88 445
7 ★	Wrong Body Part	262 656	84 921	37 210
4 ★	Retained Foreign Body	204 054	76 663	34 622

★ HAC/never events

JOURNAL OF HEALTHCARE RISK MANAGEMENT • VOLUME 33, NUMBER 4

Montefiore

Multiple opportunities were missed by all members of the team to prevent an adverse event.



Montefiore THE UNIVERSITY HOSPITAL

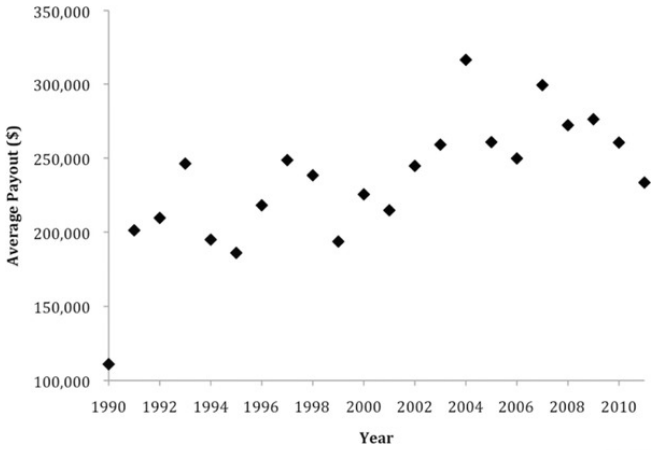
EINSTEIN Albert Einstein College of Medicine

Secondary Drivers of Malpractice

- Communication
- Teamwork
- Failure or delay in obtaining a consult
- Diagnostic tests
  - Failure or delay in ordering
  - Misinterpretation
- Failure to establish a differential diagnosis
  - Treating a patient on the assumption that the prior diagnosis was correct

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Average Yearly Payout Between 1990 and 2011 in Inflation Adjusted 2012 Dollars



JOURNAL OF HEALTHCARE RISK MANAGEMENT • VOLUME 33, NUMBER 4

Montefiore

Impact of Malpractice on Surgeons

Surgeons involved in malpractice suites

- Younger, worked longer hours and more night call
- Related to burnout, depression
- Less likely to recommend careers in surgery or medicine
- Second victims need appropriate counseling

JACS Vol. 213, No. 5, 2011

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Why Do Patients File Malpractice Suits?

- Obvious deviation for the standard of care
- Financial motivations
- Need to find answers
  - concern about a cover-up/poor communication
- Opinion outside of the care team suggested the care was substandard
- Patient dissatisfaction

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Patient Complaints and Malpractice
(Why some may file)

Physicians who have high numbers of patient complaints are:

- A subset linked to a disproportionate number of complaints
  - 9% are associated with 50% of complaints
- Responsible for high proportion of indemnity reserves
- Associate with >50% of dollars paid out and involved in high dollar cases
- Associated with lower patient satisfaction scores (HCAHPS)
- Not limited to specific medical specialties
- Similar explanations or pushback for the patient complaints

http://www.mc.vanderbilt.edu/centers/cppa/whatwehavelearned.html

Montefiore THE UNIVERSITY HOSPITAL

EINSTEIN Albert Einstein College of Medicine

To Reduce Premiums

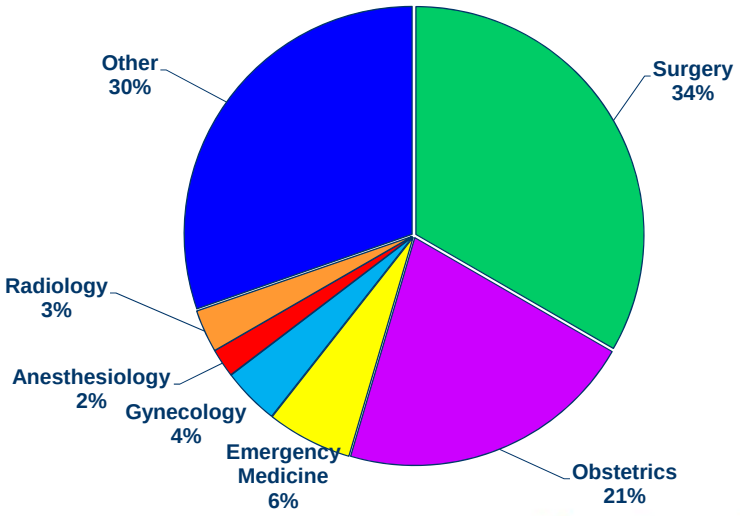
- Spread the cost
- Cut the cost
- Prevent the cost

Montefiore

Can we reduce malpractice claims with quality initiatives?

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Cost (Open and Closed Claims) – 2001-2010



Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Montefiore

Surgical Safety Initiative: Collaboration between

Montefiore Medical Center
Mount Sinai Health System
Maimonides Medical Center
Sponsored by HIC/FOJP

Goals

- Encourage change in culture and practice
- Reduce adverse outcomes
- Increase defensibility
- Increase operational efficiencies
- Premium discounts

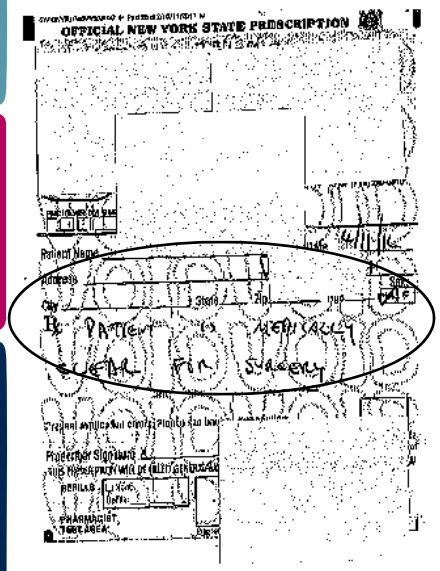
Montefiore

Surgical Safety Initiative

- OR team training- TeamSTEPPS
- Pre-Operative Medical Assessment
- Care of obese surgical patients – BMI≥40
- Co-management/perioperative medicine

Montefiore

Preoperative Medical Evaluation



→ "Patient is medically clear for surgery"

Montefiore

MR#: [redacted]

October 11, 2011

Re: A[redacted]

To Whom It May Concern:

Mr. A[redacted] agnosed with Non-Hodgkin's Lymphoma and recently received an Autologous Stem Cell Transplant on [redacted]. He is currently on prophylactic post-transplant medications. [redacted] medically able to be scheduled for surgery. Please do not hesitate to contact me if you have further questions/concerns.

Kind regards,

[redacted]
Montefiore Medical Center
Bronx, NY 10467
Tel: (7[redacted]
Fax: ([redacted]

Sample: Medical "Clearance"

Patient's Name _____ Date __/__/__ Age __ Sex: M F

GENERAL INFORMATION - Please provide history in appropriate area and provide copies of relevant tests.

Cardiac (e.g.: HTN, MI, angina, CHF, valvular, PVD, congenital, pacemaker)

EKG Interp/Date:
Echocardiogram:
EF:
Cardiac Cath:

Pulmonary (eg: asthma, COPD, restrictive, sleep apnea)

PFTs
Neurological (eg: hydrocephalus, stroke, seizure, carotid artery stenosis, c-spine disease)

GI (eg: hepatitis, PUD, hiatal hernia, GI reflux)

GU/Renal (eg: CHF, dialysis)

Endocrine (eg: IDDM, NIDDM, thyroid)

Hematologic (eg: anemia, coagulation disorder)

Rheumatologic (eg: collagen vascular disease, RA)

Infectious (eg: HIV, TB)

Neoplastic

Psychiatric

Surgical History (eg: hardware, implants)

Allergies n/kDA

Medications Prolong 0.24.

Social History (smoking, alcohol, drugs) NO-

Physical Examination:
Ht: 189 Wt: 516
P: 84 BP: 124/70

PS is cleared for surgery -

Additional Comments (use second sheet if necessary)

Patient is in optimum condition for surgery? No ☐ Yes ☒
M.D. Signature [redacted] Telephone [redacted]
Print name [redacted] Fax: _____

PLEASE FAX COMPLETED FORM TO : [redacted]

Adequacy of Pre-operative Evaluation

Anesthesiologist Survey ASA III & IV Patients
FOJP Hospitals

Question	Response	
	YES	NO
Were all preoperative medical problems identified when I first evaluated the patient?	90%	10%
Were all preoperative medical problems adequately addressed when I first evaluated the patient?	85%	15%
Were all relevant consults obtained?	89%	11%

n=468, November 2011

Author of Pre-operative evaluation

FOJP Hospitals-Survey ASA III & IV Patients

Chart Review-data element	% present
Medical attending authored	42
Other provider authored, attending co-signature	12
Other provider authored, no attending co-signature	10
Not present in medical record	35

n=195, November, 2011

What is the solution?

Pre-Operative Medical Assessment Reference

Montefiore THE UNIVERSITY HOSPITAL

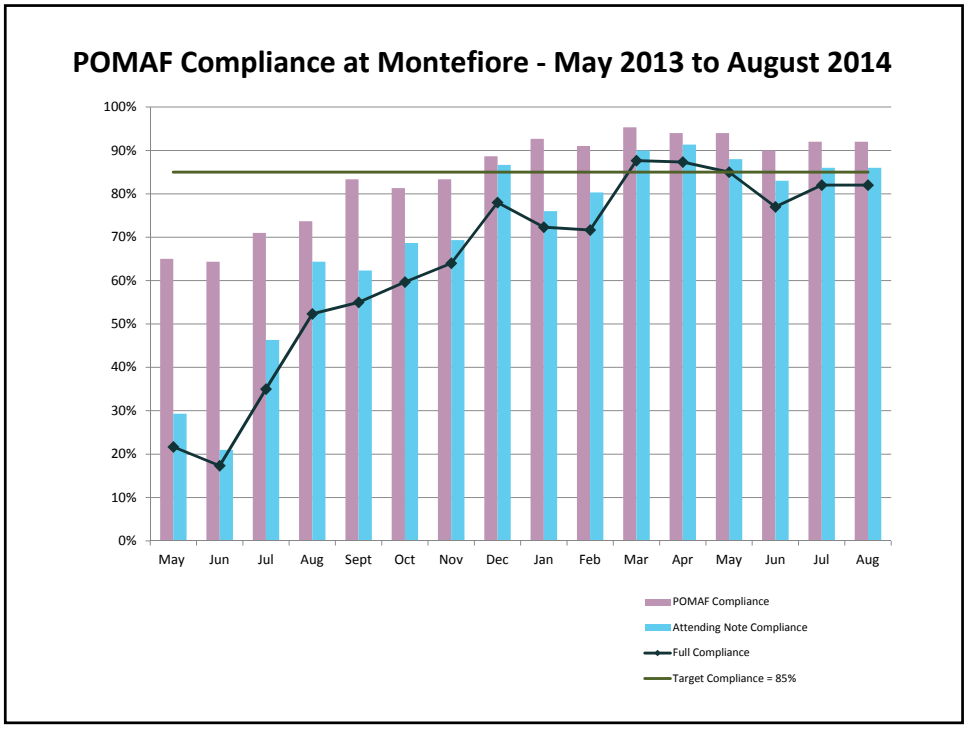
EINSTEIN Albert Einstein College of Medicine

Pre-Operative Risk Assessment Requirements

- Completion of Pre-Op Risk Assessment Form (POMAF)
  - All adult patients with significant co-morbidities (ASA III and IV)
- Internal Medicine
  - Complete form
  - Attending signature
- Surgeons
  - Attending Surgeon Pre-op note that refers to POMAF
- Exceptions
  - Emergent life threatening cases
  - Must document emergent case in Attending Surgeon Pre-op note
  - Anesthesia must classify as ASA IIIE or IVE

Montefiore THE UNIVERSITY HOSPITAL

EINSTEIN Albert Einstein College of Medicine



Co-management of Surgical Patients

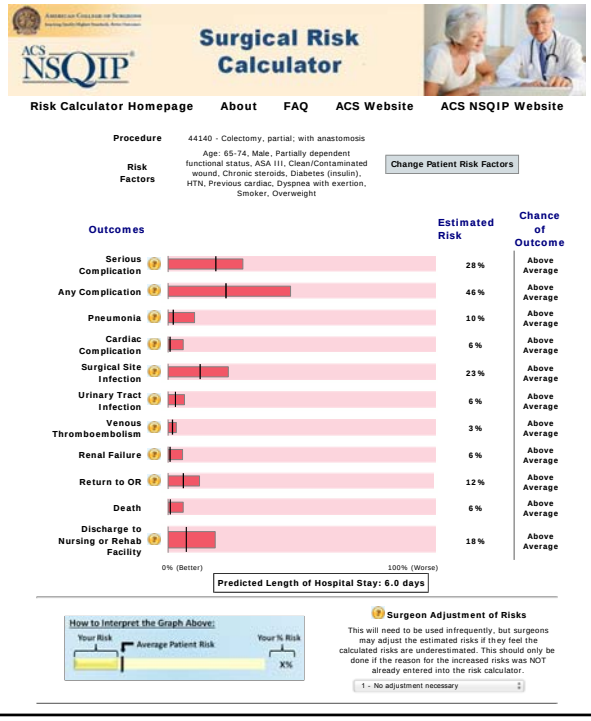
- Moses Division Vascular Surgery patients
- Designated medical hospitalist collaboratively manages surgical patients, no other clinical responsibilities
- Daily notes by Attending Surgeon and Hospitalist
- Outcome data based on NSQIP measures

Montefiore THE UNIVERSITY HOSPITAL

EINSTEIN Albert Einstein College of Medicine

American College of Surgeons (ACS) National Surgical Quality Improvement Program Evaluation of Co-managed Patients

- Data-driven, risk-adjusted, outcomes-based surgical quality improvement program
- Co-managed patients data abstracted and entered into NSQIP data base
- Predicted outcomes determined using NSQIP calculator
- Observed to expected ratio calculated



Outcome Benefits of Co-Managed Patients – NSQIP analysis

Outcomes	Observed Rate	Expected Rate	O/E Ratio	Trend
Length of Stay	8.96	5.11	NA	●
Death	1.80	2.78	0.65	●
Serious Complication	11.98	21.23	0.56	●
Any Complication	15.57	27.52	0.57	●
Pneumonia	1.80	1.96	0.92	●
Cardiac Complication	0.60	2.26	0.26	●
Surgical Site Infection	3.59	4.76	0.75	●
Urinary Tract Infection	1.20	2.32	0.52	●
Venous Thromboembolism	0.00	1.28	0.00	●
Renal Failure	2.03	2.11	0.96	●
Return to OR	6.59	15.15	0.43	●

(n=167)

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Recommendations on Improving Quality of Care and Reducing Malpractice Risk

- Careful documentation
- Consistent effective communication
- Collaborative care

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Questions?

Montefiore

Redefining Professionalism

Professionalism = Accountability

Autonomy	→	Collaboration
Authority	→	Evidence
Assertion	→	Measurement
Control	→	Transparency
Self-interest	→	Public Interest
Fee for Service	→	Payment for Quality

Montefiore

Agency for Health Care Research and Quality TeamSTEPPS program

- Trained a multidisciplinary team of peri-operative champions
- All OR personnel participated in a hospital-based training curriculum
- Observation program pending

Montefiore

Teamwork

"…poor care is inevitable when a complicated patient is cared for by myriad individuals who have not been trained to communicate effectively as a team."

Gerald B. Healy, MD, FACS
Presidential Address
93rd Clinical Congress – American College of Surgeons
October 8, 2007

An expert team!

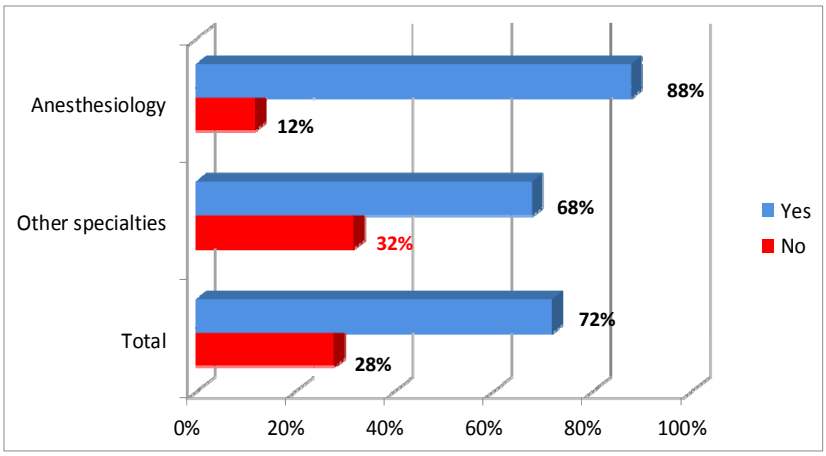
Montefiore

Care of the Obese Surgical Patient:

Montefiore

Anesthesia/Surgery Attending Survey

Change in practice for patients with BMI≥40



Montefiore

Care of the Obese Surgical Patient

Goals for Compliance-Practice Standards:

1. Supplemental informed consent
2. Pre-operative medical assessment form completed
3. Nursing assessment on admission and post-op
4. Preoperative documentation plan for VTE prophylaxis
5. Documentation of two anesthesia providers at the time of induction
6. PACU dicharge note authored by an attending anesthesiologist
7. Documentation of CPAP availability
8. Difficult airway cart and/or advanced airway technology in OR
9. Appropriate size equipment for obese patients available in the OR and units
10. Perioperative nursing staff attend yearly in-service on care of obese patients
11. Pain management protocol for obese patients

Montefiore

Supplemental Informed Consent for all patients BMI≥40

INFORMED CONSENT FOR SURGICAL PROCEDURE
FOR BMI OVER 40

Please read each of the items on this form and initial the box to the right of each item if you understand it. Do not initial any boxes or sign this form until you have read each one fully and understood its contents.

Patient's name:_____ **Date:**_____

Planned Surgical Procedure:_____

The following has been explained to me in general terms and I understand that:

1. I have been given this BMI >40 consent form because my Body Mass Index (BMI) is over 40, which puts me at higher surgical risk for complications from surgery and during the recovery period. Initial: ☐
2. I am at higher risk of blood clot formation which may lead to a deep vein thrombosis (DVT) and pulmonary embolus (PE). To reduce this very serious risk, I may be given a blood thinner which can potentially increase the risk of bleeding. Initial: ☐
3. Increased risks of surgery and anesthesia include but are not limited to: internal infection, wound infection, allergic reaction, development of pressure sores, scarring, bleeding (possibly requiring transfusion), hernia, bowel obstruction, injury to internal organs such as the intestine, liver or spleen, possibly requiring removal of part or all of the injured organ, injury to upper or lower extremities, heart attack, stroke, airway difficulties, postoperative ability to breathe or cardiac arrest. ***There is a risk of death from this operation. My risk of complication or death may be higher because of my weight.*** Initial: ☐
4. I understand that no guarantees have been made to me concerning the results of this procedure. Initial: ☐
5. ***I acknowledge that I have read this form and that I fully understand its contents. All my questions have been answered satisfactorily. Any blanks I do not approve of were stricken before I signed this form.***

I hereby voluntarily consent to the performance of the procedure as described above by my surgeon and any other physicians, physician assistants, nurses or other medical personnel who may be involved in the course of my treatment.

_____
Person Giving Consent Date

_____ _____
Witness Date Surgeon Date

Best practices for obstetrics

- Collaboration of 4 New York City Hospitals
- Including implementation of evidence-based protocols,
- Standardized educational interventions
- Mandatory electronic fetal monitoring training
- Guidelines requiring improved documentation
- Each institution to develop a unique safety-related area of expertise that they would ultimately share and disseminate across the collaborative

Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Improved obstetric safety through programmatic collaboration

Best Practices for Obstetrics

Admission Note
- *Latent phase* – within 12 hours
- *Active phase* – within 4 hours
- Include history, exam, fetal assessment, plan of care and EFW

Progress Notes
- *Latent phase* – every 8 hours
- *Active phase* – every 4 hours
- *Stage 2, nullipara* – within first 2 hours and then hourly
  multipara – within first hour and then hourly
- Include labor progress, FH monitor findings, interventions, and plan of care

Attending Coverage
- Primary or covering attending must be in-house and readily available for patients:
  - In labor
  - Receiving oxytocin
  - With epidural
- Covering attending will:
  - Act on behalf of primary attending in an emergency
  - Document at beginning and end of coverage period
- Primary attending must come in immediately when called by covering attending

Oxytocin Use
- When initiating – document need based on evaluation and assessment
- Document agreement between covering and primary attendings to start oxytocin
- Continuous fetal monitoring required
- *Latent phase* – reassess and document every 8 hours
- *Active phase* – reassess and document every 2 hours
- Discontinue for non-reassuring FHR

Suspected Macrosomia
- Recommend C/S for:
  - EFW >4500 grams in *diabetic* mothers
  - EFW >5000 grams in *non-diabetic* mothers

Best Practices for Obstetrics

Refusal of Treatment
- Document when patient refuses C/S or any recommended procedure

Operative Vaginal Delivery
- Do not attempt if:
  - EFW >4000 grams in *diabetic* mothers
  - EFW >4500 grams in *non-diabetic* mothers
- Pre-op requirements:
  - Instrumentation privileges
  - OR availability, if C/S necessary
  - Examined for position
  - Station at least +2
  - Cervix fully dilated
  - Pelvis clinically adequate
  - Analgesia adequate
  - Bladder empty
- Use forceps ***or*** vacuum – NOT both
- Perform vacuum delivery only after 34 weeks
- Limit to 3 pop-offs or complete lack of descent
- Document:
  - Pre-op requirements met
  - Delivery procedure in detail
  - Pop-offs, if applicable

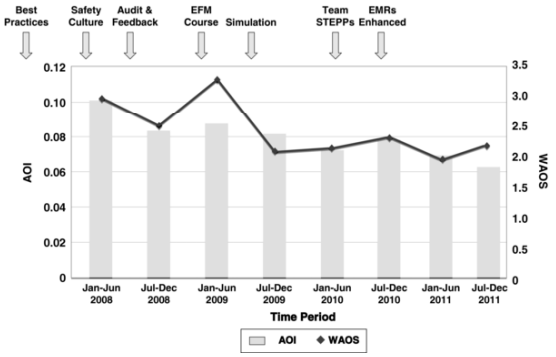
VTOL / VBAC
- Document risk / benefit discussion and consent
- Use special caution for patients:
  - With unknown scar
  - Unregistered to the institution
  - Whose records are unavailable
- Contraindications:
  - Prior upper segment incision
  - Prior T-incision
  - Prior uterine rupture or dehiscence
  - Clinical assessment of inadequate pelvis

Management of Twins
- Inability to monitor second twin precludes trial of labor
- Must deliver in OR

Elective Deliveries
- Singletons – not before 39 weeks without FLM results
- Twins – not before 38 weeks without FLM results

Journal of Healthcare Risk Management
Volume 33, Issue 3, pages 14-22,,2014

Improved obstetric safety through programmatic collaboration



- Analysis of 19,189 deliveries January 2008 through December 2011
- Adverse Outcome Index (AOI) decrease 42% (from 10.7 % to 6.2 %)
- Weighted Adverse Outcome Score (WAOS) decreased from 3.9 to 2.3.
- AOI = # deliveries affected adverse outcomes/ total number of deliveries
- WAOS= weighted to account for the severity of injuries

Journal of Healthcare Risk Management
Volume 33, Issue 3, pages 14-22,,2014

Five Stages of Grief

Denial- The data is wrong 

Anger- It does not apply to me 

Bargaining- I will get the correct data 

Depression- There is nothing I can do about it 

Resolution- Acceptance and action 

Adapted from Elisabeth Kübler-Ross 5 stage model

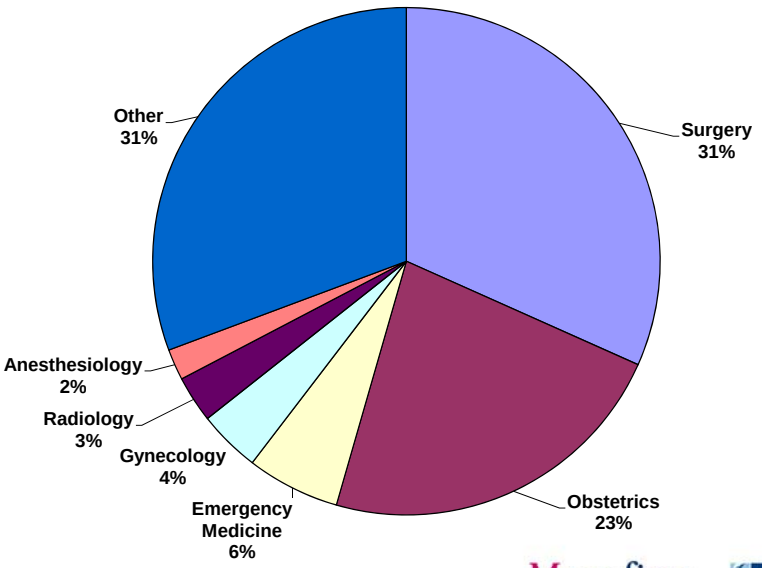
Montefiore

It isn't reasonable to ask that we achieve perfection. What is reasonable is that we never cease to aim for it.

Atul Gawande

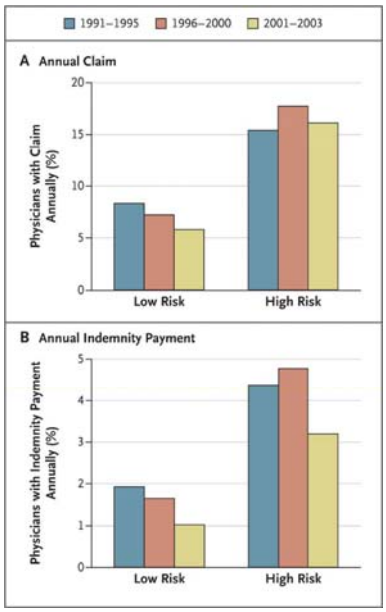
Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Cost (Open and Closed Claims) – 2000-2009



Montefiore THE UNIVERSITY HOSPITAL EINSTEIN Albert Einstein College of Medicine

Trends in Overall Claims and Claims with an Indemnity Payment, According to Risk of Specialty.



Jena AB et al. N Engl J Med 2011;365:629-636

Montefiore

Summary Statistics for Physician Specialties.

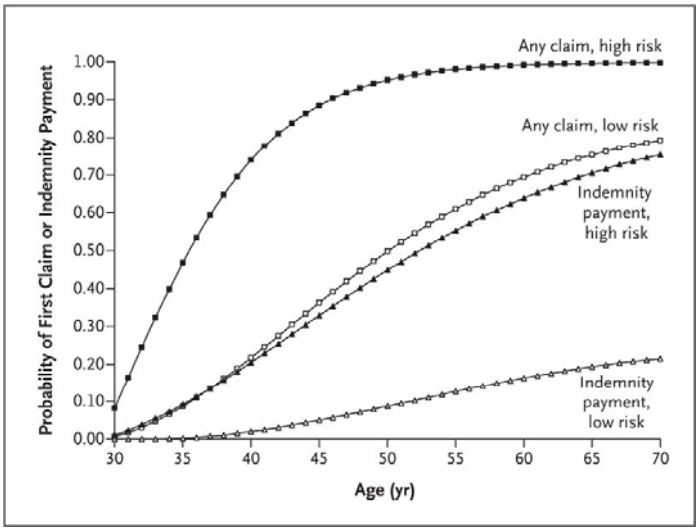
Table 1. Summary Statistics for Physician Specialties.*

Specialty	Physician-Years of Coverage	No. of Physicians	Physician Age	Coverage Years per Physician
	no.		yr	no.
All physicians	233,738	40,916	49.0±9.5	7.2±4.4
Anesthesiology	29,952	5,037	45.6±8.5	7.2±3.9
Cardiology	4,155	777	49.8±8.9	5.9±4.4
Dermatology	3,627	532	47.8±9.9	8.0±5.1
Diagnostic radiology	4,905	808	48.6±9.1	6.6±4.3
Emergency medicine	1,631	352	43.2±8.1	4.8±3.3
Family general practice	25,758	4,975	48.9±9.7	6.2±4.2
Gastroenterology	3,981	639	50.2±8.6	7.0±4.7
General surgery	7,352	1,205	48.9±9.4	7.2±4.5
Gynecology	2,577	459	53.0±9.1	5.8±3.9
Internal medicine	27,268	4,905	47.8±9.4	7.2±4.6
Nephrology	1,373	248	47.2±9.1	7.3±5.0
Neurology	3,037	519	48.4±8.4	6.6±4.8
Neurosurgery	1,927	351	48.6±8.2	5.1±3.2
Obstetrics and gynecology	10,385	1,899	47.5±9.0	6.2±3.5
Oncology	1,207	245	49.8±7.9	6.1±3.5
Ophthalmology	5,203	807	50.0±9.9	7.6±4.9
Orthopedic surgery	11,928	2,224	48.3±8.9	6.0±4.4
Pathology	20,717	3,094	51.8±9.6	9.5±4.3
Pediatrics	7,381	1,616	45.8±9.4	5.2±4.1
Plastic surgery	11,882	1,862	47.4±9.0	7.6±4.4
Psychiatry	19,011	3,011	52.5±8.7	6.6±3.5
Pulmonary medicine	2,362	380	47.5±8.2	7.7±5.0
Thoracic–cardiovascular surgery	3,187	437	50.6±9.1	8.7±4.6
Urology	2,328	368	51.9±9.3	7.3±4.9
Other specialty	20,604	4,166	47.3±9.7	5.4±4.0

* Plus–minus values are means ±SD. All calculations were performed with the use of a database of physicians covered by a large, multistate liability insurer. The numbers of physician-years and physician observations are reported for all physicians between the ages of 30 and 70 years during the period from 1991 through 2005.

Jena AB et al. N Engl J Med 2011;365:629-636

Cumulative Career Probability of Facing a Malpractice Claim or Indemnity Payment, According to Risk of Specialty and Age of Physician.

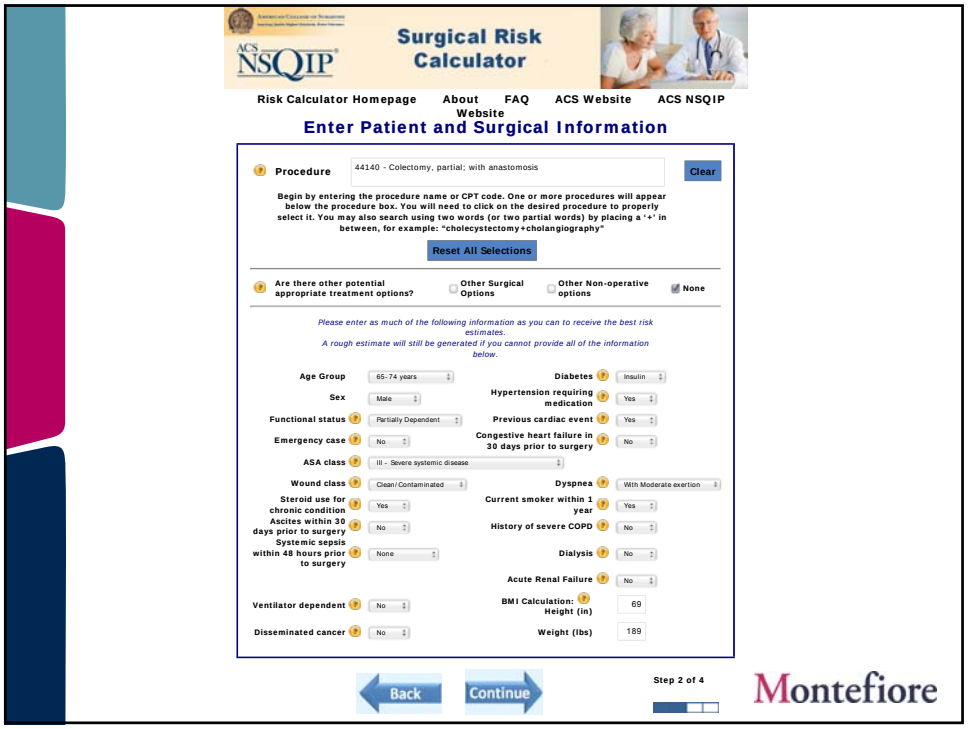


Jena AB et al. N Engl J Med 2011;365:629-636

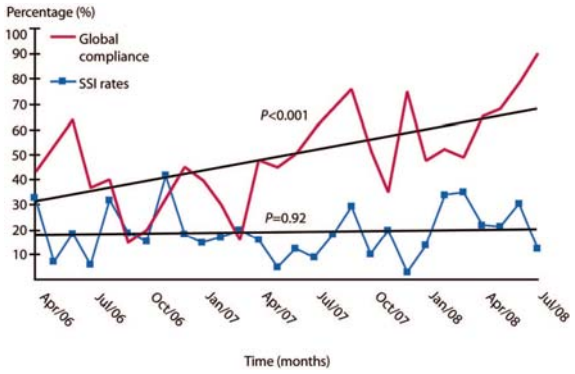
Conclusions

- There is substantial variation in the likelihood of malpractice suits and the size of indemnity payments across specialties.
- The cumulative risk of facing a malpractice claim is high in all specialties, although most claims do not lead to payments to plaintiffs.

Montefiore



Improvement in SCIP Antibiotic Compliance does not Reduce Colon SSI Rates



Dis Colon Rectum 2010; 53: 24–30

The Effect of Surgical Care Improvement Project (SCIP) Compliance on Surgical Site Infections (SSI)

Guido Cataife, PhD, Daniel A. Weinberg, PhD,* Hui-Hsing Wong, MD, JD,† and Katherine L. Kahn, MD‡*

- SSI rates obtained from Medicare claims data
- SCIP rates extracted from Hospital Compare
- Hospitals with higher rates of SCIP compliance for antibiotic timing and selection had lower SSI rates
- 10% increase in compliance with timing of antibiotics led to a 5.3% decrease in SSI rates
- Timely discontinuing antibiotics had no effect on SSI

Medical Care • Volume 52, Number 2 Suppl 1, February 2014

Malpractice Risk According to Physician Specialty
NEJM 365(7):629-636, 2011

The NEW ENGLAND JOURNAL of MEDICINE

What we need to do…

- Interdepartmental multidisciplinary efforts
- Clinically relevant targets of care
- Clinicians educated on the standards
- Development of workflows
- Feedback on performance with benchmarks
- Structured process designed to reduce provider variability which can be monitored

Montefiore

J Healthc Risk Manag. 2014 Sep;34(2):31-42. doi: 10.1002/jhrm.21156.
Analysis of patient injury based on anesthesiology closed claims data from a major malpractice insurer.
Ranum D1, Ma H, Shapiro FE, Chang B, Urman RD.

Reducing Risk with Clinical Decision Support Journal:Applied Clinical InformaticsISSN:1869-0327DOI:http://dx.doi.org/10.4338/ACI-2014-02-RA-0018Issue:Vol. 5: Issue 3 2014Pages:746-756

- Journal of Patient Safety:
- Post Author Corrections: November 13, 2014
- doi: 10.1097/PTS.0000000000000136

Montefiore

"Instead of payment that asks, *How much did you do?*, the Affordable Care Act clearly moves us toward payment that asks, *How well did you do?*, and more importantly, *How well did the patient do?*"

Don Berwick

Montefiore

Value-Based Purchasing (VBP) Review

- Introduced in FY 2013 with 2 domains
  - Clinical process- Core Measures
  - Patient experience- Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS)
- Expanded in FY 2014 and FY 2015
  - Outcomes domain
  - Efficiency domain (FY 2015 only)
- Hospital performance is relative to all eligible hospitals
  - Achievement Scale
  - Improvement Scale
- Two year lag from performance and payment adjustments
- At risk- 1% Base DRG operating payments
  - Increases to 2% in FY 2017

Montefiore

CMS Reporting Requirements on Hospitals

2003

- Hospital Inpatient Quality Reporting Program Authorized
- 100% process measures

2008

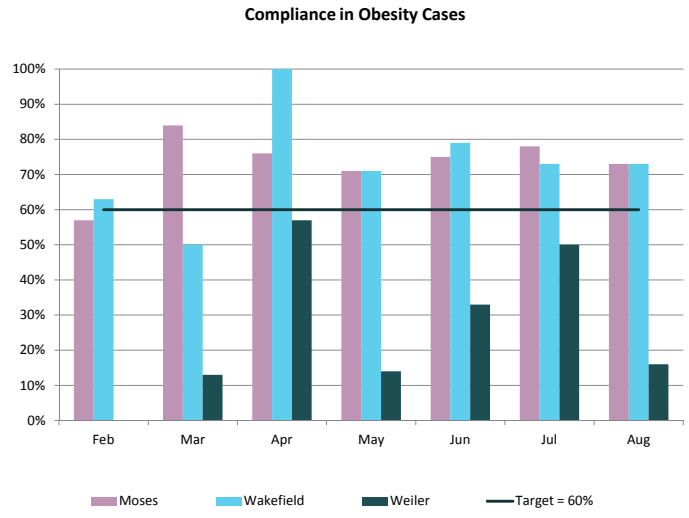
- Public display of quality data begun on *Hospital Compare*
- Process measures
- Patient Experience

2010

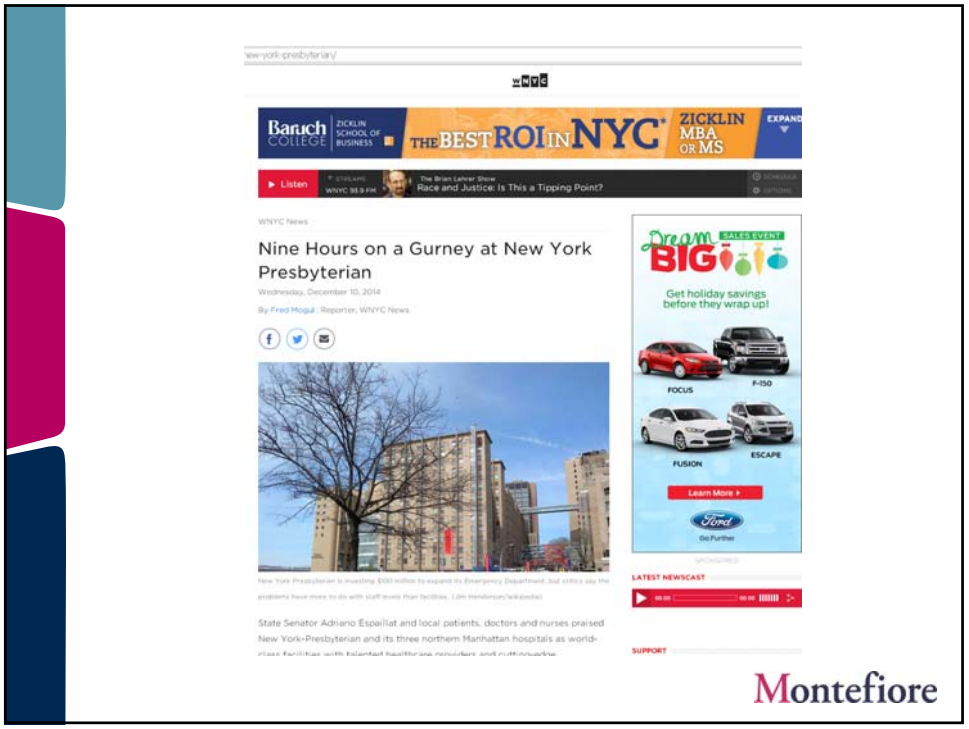
- Affordable Care Act (ACA)
- Emphasis shifted from processes to outcomes
- Mortality

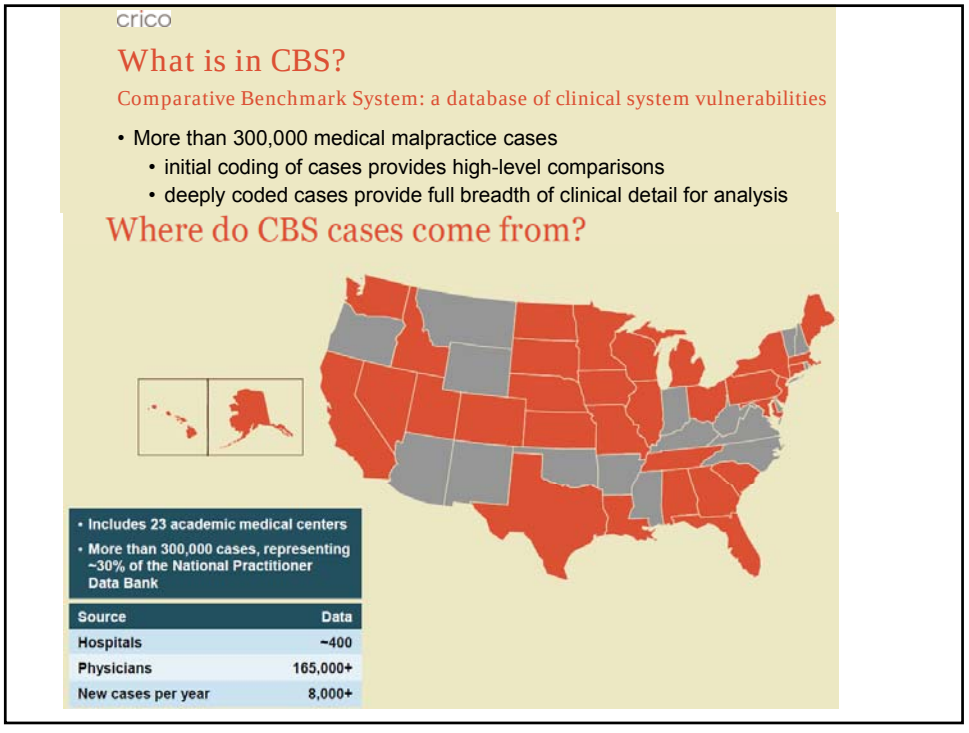
Montefiore

Care of The Obese Surgical Patient



Montefiore


Baruch College
Zicklin School of Business
THE BEST ROI IN NYC
ZICKLIN MBA OR MS
EXPAND
Listen
Race and Justice: Is This a Tipping Point?
WNYC News
Nine Hours on a Gurney at New York Presbyterian
Wednesday, December 10, 2014
By Fred Mogul, Reporter, WNYC News
State Senator Adriano Espaillat and local patients, doctors and nurses praised New York-Presbyterian and its three northern Manhattan hospitals as world-
Dream BIG
SALES EVENT
Get holiday savings before they wrap up!
FOCUS
F-150
FUSION
ESCAPE
Learn More
Ford
Go Further
LATEST NEWSCAST
SUPPORT
Montefiore


crico
What is in CBS?
Comparative Benchmark System: a database of clinical system vulnerabilities
• More than 300,000 medical malpractice cases
• initial coding of cases provides high-level comparisons
• deeply coded cases provide full breadth of clinical detail for analysis
Where do CBS cases come from?
• Includes 23 academic medical centers
• More than 300,000 cases, representing ~30% of the National Practitioner Data Bank
Source
Data
Hospitals
~400
Physicians
165,000+
New cases per year
8,000+

crico

4,662 cases | $664M total incurred

Cases related to improper performance of surgery are most prevalent.

TOP ALLEGATIONS	% CASES	TOTAL INCURRED
Improper performance of surgery	48%	$402,741,891
Improper management of surgical patient	13%	$190,920,487
Retained foreign body, surgical	4%	$19,276,308
Surgery, other	2%	$10,728,376
Unnecessary surgery	2%	$15,426,844
Delay in surgery	1%	$25,164,081

N=4,662 MPL cases asserted 1/1/09–12/31/13 with a Surgery Specialty as the primary responsible service and surgical treatment as the major allegation.

crico

6,712 cases | $940M total incurred

Technical skill and clinical judgment factors are most prevalent in surgery-related cases.

CONTRIBUTING FACTOR CATEGORY	% CASES*
Technical Skill	53%
Clinical Judgment	41%
Behavior-related	28%
Communication	23%
Documentation	12%
Administration	10%

TOP TECHNICAL SKILL FACTORS	% CASES*
Technical performance—possible technical problem	35%
Technical performance—poor technique	7%
Retained foreign body(material/instruments)	4%
Technical performance—misidentification of an anatomical structure	3%

TOP CLINICAL JUDGMENT FACTORS	% CASES*
Selection/management therapy—surgical/invasive procedures	13%
Pt assess—failure/delay in ordering diagnostic test	8%
Pt assessment—narrow dx focus—failure to establish differential diagnosis	5%

TOP BEHAVIORAL FACTORS	% CASES*
Patient factors—seeking other providers due to dissatisfaction w/care	14%
Patient factors—noncompliance with treatment regimen	6%
Patient factors—noncompliance with follow up call/appointment	4%

*A case will often have multiple factors identified.

N=6,712 MPL cases asserted 1/1/09–12/31/13 with a surgical specialty as the primary responsible service.