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Introduction

A new tool to help primary care providers manage prostate care and screen for prostate cancer.

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And...a way to cut human and financial costs of medical error—by turning patient safety data into change.

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New Decision Tool for Prostate Cancer Testing

When it comes to medical malpractice cases alleging missed or delayed diagnosis of cancer in the Harvard medical system, the Number One category is prostate cancer. This accounted for nearly \$16 million in incurred losses between the years 2004 and 2008.

In those prostate cancer-related liability cases, 23 physicians, nine organizations, and two nurse practitioners were named as defendants.

Most professional organizations recommend that physicians at least discuss prostate cancer screening with patients over age 50, or younger with risk factors. But the consensus ends there. Uncertainties about the risks and benefits of early detection and treatment of what is often a slow-moving, non-lethal cancer challenge doctors and their patients.

The issues behind screening and diagnosing prostate cancer with a prostate-specific antigen—or PSA—test are complex. Routine PSA testing is controversial because of a high rate of false positives and false negatives and a lack of agreement on the benefit of a test that can lead to treatments with high morbidity and low benefit.

To help primary care physicians navigate these treacherous waters, a Harvard task force has come up with a decision support tool. Dr. Mark Garnick was a member of the task force that developed the tool.

Dr. Garnick is a medical oncologist and a clinical professor in the Department of Medicine at Beth Israel Deaconess Medical Center in Boston.

“I think the group of professionals that have the toughest time and have the hardest tasks are the primary care physicians, and one of the patient populations that causes the most angst in the primary care physicians is an individual that has a PSA detected, screened detected cancer that the primary care physician has sent off to surgery for a radical prostatectomy, and the primary care physicians end up questioning themselves whether or not they actually did the right thing by sending the patient off especially if they had, you know, a cancer that had very, very low risk features.”

Research into whether or not PSA testing and even early prostate cancer detection improves patient outcomes is contradictory, and the advice from national organizations has been vague or conflicting. In March 2009, studies from two large randomized trials published in the *New England Journal of Medicine* confused the matter further. One study showed no significant reduction in mortality in control groups given PSA screening, and the other showed a 20 percent reduction in prostate cancer mortality accompanied by a high rate of overdiagnosis and treatment morbidity.



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If PSA testing doesn't lead to improved outcomes, elevated values can clearly lead to treatments that increase morbidity for men who choose immediate treatment. Biopsy carries a certain risk of infection, and side effects of radiation or surgery may include incontinence or impotence.

Consensus from professional organizations on the details of PSA testing has been hard to come by. The U.S preventive task force recommends PSA testing not be offered in men over age 74, but has been silent about men *under* that age, and the American Cancer Society has said it should be offered to every man over age 50, or 45 with risk factors. Dr. Garnick:

“What we are trying to do now is to provide a decision tool for primary care physicians where really the key factors about the issues, the facts that are known, the facts that are controversial, the ambiguous facts about PSA-based screening, are laid out in a fairly concise document so the primary care physician will be in a very, very good position to discuss the aspects, the pros and cons, and have a discussion with the patient about the pros and cons of PSA-based testing in the first place.”

The Harvard team came from several different hospitals and represented knowledge from four disciplines closely involved in prostate cancer on a day-to-day basis: general internal medicine, urology, radiation oncology, and medical oncology.

They reached agreement on suggestions for primary care doctors in three key areas: how to communicate with patients about prostate care, when to offer PSA testing, and how to follow-up once a PSA test is done.

“The guideline includes some case studies of physicians that have been the subject of medical malpractice suits based upon PSA-based testing. It provides some general and prostate-specific cancer testing risk management, and the critical thing there is that we believe the important thing for primary care physicians to do is to discuss the pros and cons of PSA-based testing, to document that such a discussion has taken place, and to document that a decision has been made by the patient of whether he does or does not want to get tested.”

Dr. Richard Parker is an internist in primary care who reviewed the Harvard decision support tool. Dr. Parker is medical director for the Beth Israel Deaconess Physician Organization in Boston, and has served as an expert witness in numerous medical malpractice cases involving prostate cancer diagnosis.

“I've seen several allegations in the prostate cancer arena. Number One would be the allegation that the doctor never offered the test and the man ended up with prostate cancer and sued. The next would be that the doctor ordered the test, it



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came back elevated, abnormal, and the doctor or the doctor's office never notified the patient; there was some slip-up in communication. The third one I've seen is a patient put on testosterone therapy where a PSA was never checked, and the patient ended up with prostate cancer, which violates one of the principles that's clear in the guideline."

Agreement does exist about the need to talk about the prostate, and discuss the availability of PSA testing with every male patient between ages 50 and 75, and with males age 45 and over if they have risk factors, such as family history of prostate cancer or African American heritage.

Once PSA testing is initiated for a patient, the ordering physician must have reliable systems in place to ensure that results are assessed in a timely way and repeat testing is done at appropriate intervals.

The Harvard decision support document states that physicians should not simply order the test on all patients over 50 without a consent discussion, in an effort to save time. Dr. Parker says an efficient discussion of PSA testing does not have to be lengthy:

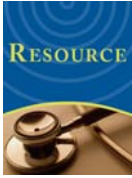
"I think this is one of the myths about informed consent, which is I don't really believe it takes a lot of time. The doctor has to consider the topic and has to introduce it to the male patient, but it really doesn't take more than 2 or 3 minutes to briefly discuss the implications of the test and ask the man whether he would like it or not."

According to Dr. Parker, many physicians mistakenly think they are protecting themselves legally by ordering the test for all their male patients over 50. However, he maintains that the best legal protection is to practice appropriate medicine and document your actions and patient discussions.

As the large randomized trials mature, the data may reveal more conclusively whether PSA testing's benefits outweigh the risks.

In the future, it may be possible to have a way to help determine which prostate cancers will grow quickly and kill a patient without intervention. Dr. Garnick:

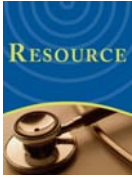
"In my own practice, for example, I would say that close to 30% of the patients that I see with newly diagnosed prostate cancer actually opt to have active surveillance with delayed intention to treat, and this is a group of patients that are well defined in terms of what their biopsy scores show, what their Gleason component is, what their PSA value is, what their digital rectal examination shows. And these patients in the past would have been almost universally treated with either surgery or radiation therapy. These patients are actually coming back



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on a periodic basis—generally every 3-4 months and then getting rebiopsied with sequential prostate biopsies to determine if their cancer is becoming active and whether or not the patient needs treatment at that point.”

The CRICO/RMF PSA Decision Support Tool is available online at www.rmfm.harvard.edu.



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Closed Case Abstract

Drug Error Reviewed by Non-Healthcare Methods

The following case abstract is based on a true story. Names and some details were changed to protect identities.

Mrs. Grant had successful cardiac bypass surgery and was recovering in the intensive care unit. At 8:15 a.m. two days post-op, the day nurse who was just starting her rounds discovered Mrs. Grant suffering a full body seizure. A code was called, and Mrs. Grant was taken to Radiology to rule out a neurological source for the seizure. The radiological examination proved negative, but a blood test from the code included an undetectable serum glucose level. Efforts to raise her blood sugar were unsuccessful. Mrs. Grant fell into a coma, and died following withdrawal of life support.

This case was related at a patient safety conference in Palo Alto, California, co-sponsored by Stanford University Medical Center and Harvard's CRICO/RMF. To help analyze the case, the speaker applied process improvement techniques from non-healthcare industries.

Steven Spear is Senior Lecturer at MIT, and a Senior Fellow at the Institute for Healthcare Improvement. Spear has written extensively about how exceptional organizations create competitive advantage through the strength of their internal operations.

After describing the case, Spear explained that a traditional root cause analysis was done at the hospital. The investigation concluded that the night nurse accidentally gave Mrs. Grant insulin instead of heparin in response to an alarm, as they were in similar-looking vials next to each other on the cart.

According to Spear, an effective process breakdown analysis would go beyond blaming the nurse or the pharmacy. In fact, an organization that is structured to fix problems before they hurt patients would have turned near-misses into process improvements that may have prevented Mrs. Grant's death.

Spear

Well, what really happened here is that the nurse was set up to fail because he was put in a situation where at some point, tired and in a rush, etc. etc. etc., all these human factors, environmental factors, design factors, similarly looking things in the same location used when the light is dim by a tired person, it can be easy to make a mistake.



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So you start going through, trying to point the finger of blame—and it's going around. It's going around. He said well who killed Mrs. Grant? Well at the first level literally, the nurse did. He killed the patient. Let me ask you this question, are you satisfied with that answer? Are you satisfied with that answer? Someone raise their hand if they are dissatisfied with that answer. All right, you're not satisfied, all right... So for those who couldn't hear in the back, you can't look at the last step in a whole chain of events, the whole chain is corrupt, and then blame the last step. And we do that. We do that not just in health care. We did that societally and it's not fair to do. So now the finger of blame is going around and you say, well what are the other links in the chain? Well one of the links of course is presentation of the medication

Go through this. Wait a second, the nurse did the right thing, right? He was in the correct location, responded to the alarm appropriately, thought he was treating the patient as was merited. Pharmacy did the right thing in terms of packaging and presentation, yet we have a dead patient. So the nurse did the right thing, the pharmacy did the right thing. We have a dead patient. How do you reconcile those two?

Here's the wrinkle. This gets down to one of the first reasons why we have such an extraordinary gap between what the promise is of health care and medical science technology, training, employment, and what the actual deliverable on that promise is. Pharmacy did its work relative to the standards of pharmacy. Nursing did its work relative to the standards of nursing. The problem was, pharmacy didn't do its work relative to the needs of nursing.

Said more generally, a common failure mode in very complex systems—and this is not even a very complex one, is that people do their work organized within function with adherence to the function by the standards of the function or the discipline or the specialty without a very clear insight into what the needs of the function, the discipline, the specialty, the service are, the function that it's serving.

A common failure mode in organizations responsible for pulling together, pulling together the deep, deep knowledge of people across many disciplines in order to create value—this is true in health care and it is true outside of health care—is that they manage the pieces not in service to the process, not in service to the service line but within their own isolated domain. That's one failure mode. It's a solvable failure mode. It's not necessarily easy, but it is a solvable failure mode.



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Let's say in this hospital it wasn't organized in terms of a department or department of pharmacy and department of nursing. There actually was a process called medication administration, and there was actually somebody who owned that process from when a doctor first examined a patient and wrote a script. Through the transmission of that script to the pharmacy the verification of that script is appropriate by pharmacists, the dispensing of meds by a tech, checking by a pharmacist, delivery by a delivery tech back to the nursing unit and the administration of that medication by a nurse. Let's say someone actually owned the process start to finish.

The inherent problem any time you try to design anything complex is that there are things you're gonna get wrong. Just the nature of the beast. When you have the work of many people across many disciplines, in the case of health care across many shifts, no matter what system, what process you design, there will be things wrong with it. And so then it gets to the question, what happens when people discover things wrong?

This gets to the second failure mode. So, we have a process called medication administration. We are actually managing people in service to the process, not just within their function. What happens then? This colleague I had, Anita Tucker, she tracked the nurses for 300 hours of observation. What she found was that 5 times, 10 times a shift, so every 12, every 5-10 minutes essentially, every few tasks, nurses ran into problems.

So what does a problem look like? A problem looks like a nurse goes to give medication, can't find the medication. A nurse goes to adjust the anesthesia in one of the patient-controlled pumps, doesn't have the key to let her have access, hasn't been given the day's code to let her have access. Goes into a room with contact precautions and doesn't have gowns or gloves.

The question is what does the nurse do? ...There's all this warning that the system is not operating properly. There's all this warning and nurses are constantly encountering this warning. Well here's the problem. This woman, Anita Tucker, who did these observations tallied how many of these what she called operational failures (you don't have the right thing in the right place at the right time to do your work successfully), what happened when the nurses encountered these operational failures? Ninety percent of the time when they had an operational failure, they found a way to work around it, so if they are given a medication, if they have to give a medication for which they don't have, they call the pharmacy. If they need a test result which they don't have, they call the lab. If they have to do contact precautions, either they say son of a gun, no gloves, no gowns again and they find them or they do a hand hygiene as best as possible and then to avoid brushing the patient, they kind of lean over.



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You ask yourself the question, why would a nurse work around a problem like that and not do the “right thing” and call attention to it? Well this gets down to behaviors characteristic in broken systems is that people who find themselves at the moment of operational failure face a dilemma, and I want to be absolutely clear about this. They are not lazy, they are not uncaring, they are not stupid, they are not uneducated, they are not shirking. They face a dilemma. The nature of a dilemma is really quite stark. That I can do the right thing, A, or I can do the right thing, B, but I can’t do A and B both. 90% of the time the nurses work around the problem on their own. Ten percent of the time they ask for help to work around the problem.

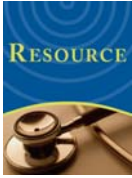
Here’s the basic fundamental problem with that is that the system in which they are working, the processes to which they are responsible are broken. They obviously are, because the right thing is not in the right place at the right time for the person who needs it to be successful in his or her work.

What they’re doing is they are suppressing that signal. It is a very, very important signal. There is something broken here. It is something which is broken which is fixable, but instead of elevating that signal and recognizing that signal and respecting that signal of here’s an opportunity to do better, that signal gets ignored. It gets suppressed. It gets squashed. And so people continue to do their work.

Coming back to Mrs. Grant’s case, it’s not as if by putting down the vial of insulin and picking up the heparin or putting down the vial of heparin and picking up the insulin or whatever else you needed, the conditions which made it easy to confuse the two disappeared. The conditions are still there. The factors are still there. The only thing is you didn’t step on the land mine, but you left it there for somebody else.

I had a student who had done a tour of duty in Iraq. You know, we’re trying to impress on students the importance of calling out the little stuff because the little stuff is an indication of vulnerability. It is an indication of potential harm down the road, and someone was really skeptical about this. Well, who has the time to do all this?

This guy volunteers and he says well, wait a second. I used to lead combat patrols up and down the roads outside of Bagdad, and the problem is we might be going up and down a patrol and depending on the time of day or the urgency of the mission to which we’re going to or coming from, etc. etc., we might actually see an insurgent planting one of these improvised explosive devices by the roadside. If we have time, we are going to stop and stop the guy and disarm the device, but sometimes we can’t because again, this dilemma problem.

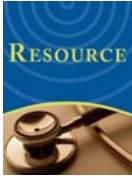


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Then he went through, he said well, what am I supposed to do when I get back to base? And of course every single student in the room raised their hands and said of course you need to tell your commander, and someone else has to go out and disarm the device because the cost of disarming the device is going to be far less than if it goes off as it is designed to go off. All right, that's the right answer there. Then he gets into the rhetorical question, you know, wouldn't it just be easier to tell everyone to be careful, wouldn't it just be easier to just pretend it's not there? Of course not, of course not, it wouldn't be.

So the ethos within health care is exactly the right thing, which is see a problem, contain a problem, solve a problem so the problem doesn't reoccur. Yet the behavior within healthcare around systems problems is exactly the opposite of that. So at this point we have talked a lot about this huge gap, here's how systems fail, structural problem and a learning and dynamic problem.

I promised to end on a very optimistic note. It is a solvable problem. There is enormous potential in the healthcare system. There's great disappointment in how it actually operates. That disappointment is entirely unnecessary. What these folks did, and what some of the hospitals I'm familiar with in Boston, and Seattle and elsewhere, New York, have done and what I'm sure many of you are doing is closing the gap one missing gown at a time.



Legal Report: Court Defines a New Harm for Losing a Chance at Survival in MA

[Narrator]

The Massachusetts Supreme Judicial Court ruled recently that the estate of a deceased patient may recover damages from a physician whose negligence did not cause the patient's death, but caused the patient to suffer a loss of chance of survival. It's a new expansion of liability in Massachusetts, which joins a growing list of states that are doing the same thing. Boston defense attorney, Philip Murray, of Murray, Kelly & Bertrand, has more in this edition of the Legal Report.

[Philip Murray]

In two unanimous decisions issued in 2008, the Supreme Judicial Court allowed a patient's family to recover damages for negligence that resulted in the loss of a chance of survival. It also discussed how such damages are to be calculated. The decisions in *Matsuyama v. Birnbaum* and *Renzi v. Parades* allow recovery based on statistical evidence and staging criteria used to prove that a delay in diagnosis likely resulted in the patient losing a chance at a better medical outcome. Since these statistics do not show that the alleged negligence actually caused the patient's death, the Court essentially defined a new harm: that is, losing a statistical chance of survival. So, if the staging criteria and statistics correlate with a general prognosis for similar patients, they may be admissible to prove the likelihood that a patient lost a chance to survive.

The *Matsuyama* case was brought on behalf of the estate of man who died of gastric cancer. The defendant, a board-certified internist, was the patient's primary care physician for the three years leading up to the diagnosis. The plaintiff contended that the defendant physician failed to comply with the applicable standard of care over that three year period; that the defendant's negligence resulted in a delay in the diagnosis of the cancer; and that the delay allowed the cancer to metastasize to an advanced, inoperable stage, resulting in the patient's premature death.

At trial, the plaintiff's expert witness described the Tumor-Lymph Nodes- Metastasis method of classifying cancer into stages. The expert testified that each higher stage reflected a more advanced cancer, with a statistically diminished chance for survival based on the metric of being five years cancer free after treatment.



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The defendant's expert witness testified that the biology of the patient's type of stomach cancer was unusual and did not show symptoms until the cancer had progressed to an advanced stage with a poor prognosis. The defense maintained that general statistics were inapplicable.

The jury returned a verdict in favor of the plaintiff, finding that the defendant was negligent in treating the patient and that the negligence was a substantial contributing factor in the patient's death. However, the jury concluded that the patient was suffering from a stage 2 adenocarcinoma and had only a 37.5% chance of survival at the time of the defendant's negligence.

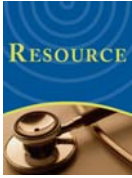
To assess the amount of the damages attributable to the doctors' negligence, the jury valued the "full" amount of damages from the patient's death at \$875,000; then it applied the 37.5 percent chance of survival that the patient lost because of the negligent delay in diagnosis, and awarded the plaintiff that proportion of the full damages, or \$328,125.

The defendant argued that Massachusetts law did not and should not allow recovery of "loss of chance" damages. The Supreme Judicial Court decided that "[w]hen a physician's negligence diminishes or destroys a patient's chance of survival, the patient has suffered real injury" that should be compensated. The Court concluded that the proportional approach most appropriately quantifies "loss of chance" damages so that the defendant "is not assessed damages for harm that he [or she] did not cause."

Similarly, in the *Renzi* case, the estate of a woman who died of metastatic breast cancer alleged that a negligent delay in diagnosis reduced the patient's chance of ten-year survival from 58% to 30%. The jury found that both defendants were negligent and that their negligence did not cause the patient's death, but that it was "a substantial contributing factor in causing [the patient] the loss of a substantial chance to survive."

In affirming the *Renzi* verdict on appeal, the Supreme Judicial Court clarified another point. It referenced the *Matsuyama* decision, and ruled that a wrongful death claim alleges a separate and distinct injury from a claim that the physician caused a loss of chance to survive. The court said that a plaintiff is not entitled to recover damages for both. Damages may be awarded only on one theory or the other.

Physicians understandably may question the reasonableness and scientific validity of permitting the recovery of damages for the loss of a chance of survival based on clinical staging criteria and related statistics. From a medical perspective, clinical staging statistics are useful for formulating treatment plans, but cannot predict the likelihood that a specific patient will have a particular outcome.



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Principles of legal causation generally require proof that the plaintiff would not have sustained a particular harm without negligence. By allowing recovery for loss of a chance of survival, the law seeks to provide some compensation to patients subjected to negligent medical treatment when the available medical evidence does not permit a determination of whether that negligence caused the death.

These decisions highlight the difference between a focus on science and a focus on resolving conflict. They impose an additional incentive on healthcare providers to aggressively pursue reliable clinical care systems that foster timely and accurate diagnoses. At the same time, future developments in scientific knowledge concerning the nature and progression of cancer in particular individuals will ultimately provide the best medical care for patients—and may limit the viability of “loss of chance” claims.



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Patient Safety Data Driving Change: A Model Methodology

Numbers are everywhere in health care safety. Data gathered through clinical quality measures... Malpractice claims... Patient complaints. But how can an organization use these patient safety numbers to reduce the human and financial costs associated with medical errors?

A gathering of medical malpractice insurers, risk managers and patient safety leaders met in Palo Alto, California, in late 2008 to consider the question. One of the answers was a model methodology described by two officers from CRICO/RMF, Harvard's patient safety and malpractice insurance company.

The methodology outlines six steps needed to drive change through a health care organization effectively—starting with numbers to identify specific risks, through measuring any change brought about by intervention.

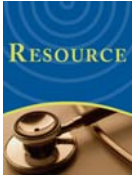
Capturing the data is just a first step, and the steps don't always start and stop neatly in sequence. Regardless of the data source, the richer the coding scheme, the better able an organization will be to pull meaning and set priorities from the data.

Dr. Luke Sato is Chief Medical Officer for CRICO/RMF at Harvard. Dr. Sato used a case to illustrate how the data can be captured and coded so malpractice cases can be aggregated to identify trends and breakdowns in the process of care.

“I would like to walk you quickly through a case. We have a middle-aged gentleman who complains of chest pain and comes to the emergency department. And through this we have basically four types of categories, access, assessment, human factors and diagnosis. We basically have a set of questions that we ask consistently in this order to approach what coding and codes to use. So for this case, for example, did the clinical team, the team in the emergency department, misdiagnose. It could be a yes or a no, and with that there's certain outcomes and then I can show you the coding results. So here are some examples of the questions that we would use. So, for example, access, was there a delay.....”

Getting an organization to take steps that will make care safer and reduce costs takes more than raw numbers, even dramatic raw numbers. Robert Hanscom is Vice President of Loss Prevention and Patient Safety at CRICO/RMF. Hanscom described how Step Two requires “framing,” or setting a context for the data.

One concrete way to do this is with comparative data or benchmarking. And again, Hanscom used a case to illustrate how it can be done.



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“And for this organization, as we are looking at their malpractice profile over the last five years, this is really what we were able to show them. You can see that their top categories starting from the left going over to the right are: general medicine first, medical subspecialty second, surgical subspecialty third, general surgery fourth, OB/GYN, orthopedics and emergency. So let me show you what we did with this organization. We have the benefit in CRICO, of course, comparing to CRICO peers, so that was the comparison of this organization to peer organizations within the CRICO system, so organizations that were similar to themselves, not community hospitals, other academic centers. So that was the first look. The second look was to compare them to academic centers from our much larger comparative bench-marking database, and you can see what that did. So now we’re comparing them really in a much broader sense, not only regionally but across the country. And what that allowed this organization to do is to say all right, this is now giving us a lot more understanding, as far as where we are probably outliers in not a good way. What they did was, they actually said these are really our priorities here. These are the areas that we want to start with.”

Other sources of data can help with the context or “framing step.” Dr. James Pichert of Vanderbilt University School of Medicine related how Vanderbilt developed a database of coded patient complaints that complemented its malpractice data.

Dr. Pichert says that doctors pay much more attention to their own numbers and are motivated to make changes, when they see the results for their colleagues. Most physicians want to know how they compare to others.

“A physician can dismiss, as from a crazy person, any single complaint. But when you develop and show that there’s a pattern over several years, and that I do stand out from the rest of my group, it can be very powerful. Sixty percent do better, just by being aware of where they stand out.”

Complementary sources of data also help with the third step in the model methodology, which is called “Ask.” In the “Ask” step, confirmation is sought to ensure that the problem still exists and whether it still looks like a priority. Bob Hanscom:

“We now get to Step Number 3, and with this organization, these were the very questions that we asked. The first one of course, are you still at risk? In today’s environment, now in the past you were, let’s talk about. So are you still at risk for unreliable receipt of critical test results? It had shown up in their malpractice data. It was the first question that we wanted to ask.”



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The answers can come through other data sources that are more contemporaneous, such as incident report data, patient complaint and resolution data, quality reporting measurements, or even practice evaluations. The fourth step in the model methodology is “Seek.” Dr. Sato:

““Seek,”” from our perspective means to look for interventions, research solutions, use the information that we have as well as best practices and knowledge that exist outside in the real world. What is actually working? And create an inventory and to apply that to the specific interventions.”

Princeton Insurance Company has joined a growing number of similar malpractice insurance organizations in pooling their data for benchmarking, using standardized coding developed at Harvard. Tom Snyder is Vice President of Healthcare Services for Princeton Insurance. Snyder said that the deep analysis of its data creates a more specific question for the “Ask” step. Deep analysis also gives direction when it’s time to seek solutions and go to the next step in the model, called “Act,” to implement interventions.

“If we look at office systems, it’s failure in follow-up, patient systems and that ties very well. So in other words, you send somebody for a colonoscopy and they never get it done and you don’t know they never got it done because you don’t follow it up. And when you combine that with the behavior related and that you see that it’s noncompliance with the treatment regimen, I mean it fits very nicely. And so again, it’s diagnosis related and it’s cancer and it’s getting the patient to do what they do and putting follow-up systems and for god’s sake document what it is that you’re doing. And if you just did it for those patients that you suspected that cancer might be an issue, it would be one really big step.”

After an action is taken, the last, and perhaps most difficult, step in the Model Methodology is called “Measure.” Bob Hanscom says start with existing metrics:

“What we try to understand is what data is the organization already collecting, that actually it doesn’t add to their work. It doesn’t add to anything other than it just helps them understand what piece of their data, what data set actually they should probably keep their eyes on a little bit closer and actually even have somebody responsible or accountable for monitoring whether or not the progress is really being made, whether or not the change has been sustained, whether or not that actually in the short term seeing improvement in that factor that was actually causing missed and delayed diagnosis in the malpractice cases.... We’re not asking them to collect more, but we’re asking them to look at your existing metrics and then pay attention to ones that are reflected in graphs and charts like these because these are the ones that are most responsible for the worst of the worst. The worst outcomes to the patients, these are responsible for the tragedies.”