



Navigating Everyday Risks: Using Data to Drive Change


2023 Loss Prevention Seminar

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Disclaimer

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Faculty *The presenters and planner of this activity have no relevant financial relationships to disclose.*


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Learning Objectives:

This enduring educational activity will support your ability to:

- Pinpoint top professional liability risk factors for physician practices
- Evaluate current practice processes associated with patient care
- Apply risk reduction strategies to reduce potential patient harm and professional liability claims

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**Everyday Risks:
Using Data to Improve
Patient Safety**



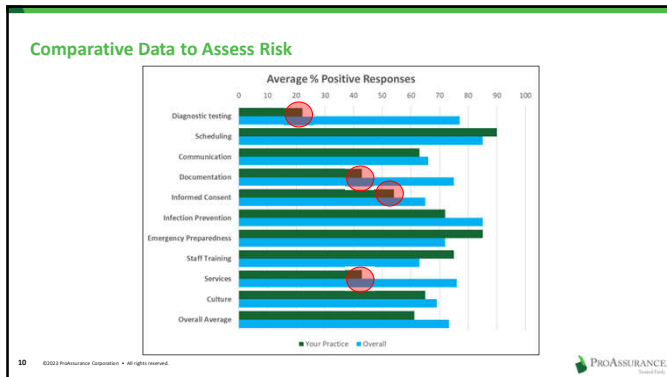
Aaron Hamming, Esq., CPHRM
Data & Technology Manager

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Diagnostic Error

- Failure to:
 - Establish an accurate and timely explanation of the patient's health problem(s) or
 - Communicate that explanation to the patient
- Process involving
 - Handoffs of information or materials
 - Constant variables
 - Diagnosis may appear over time or during an encounter
- Reduce risk means understanding the process and its variables

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Diagnostic Error: Failure to “Close the Loop”



Missed diagnosis

Safety Events occurring most often in laboratory testing & imaging
Legal claims information most often not relayed

- Imaging, lab testing, & pathology




Risk reduction strategies

Implement solutions to communicate

- Right people at the right time
- Proper format

(ECRI, n.d.)

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Diagnostic Error: Failure to “Close the Loop”

- Tracking process & monitoring:
 - Test results
 - Communication of information
 - Acknowledgement
 - Documentation
 - Follow-up
- Risk reduction strategies:
 - Identify interruptions or failure points in the process
 - Resolve & close the loop

(Balogh, Miller, and Ball 2015)

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Diagnostic Error: Case Study

- 69 YOM presents to ED & admitted
- Infectious disease physician
 - UTI secondary to enlarged prostate & partial urinary tract obstruction
 - Rule out possibility of cancer
- Post discharge patient sees physician for the first time
 - Patient history intake form filled out
 - Exam revealed multiple underlying conditions: uncontrolled & Benign Prostatic Hyperplasia (BPH) & UTI
 - BPH followed by urologist

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Diagnostic Error: Case Study

- Follow up visits continued
- Medical record did not indicate f/u on BPH
- Patient sees another physician who performs a baseline exam
- Labs obtained PSA elevated 48.6 necessitating a referral to urology
- Patient undergoes ultrasound, bone scan, & dx with metastatic prostate cancer
- Patient referred to oncology

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Diagnostic Error: Case Study

Allegations

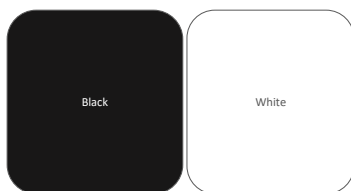
- Delayed dx, improper dx & improper treatment
- Plaintiff's expert testimony:
 - Physician had an obligation to review results of the PSA test ordered
 - Breach Standard of Care (SOC) caused a delay in dx of cancer
 - Physician failed to obtain hospital records
- Unable to secure SOC support
- Case settled

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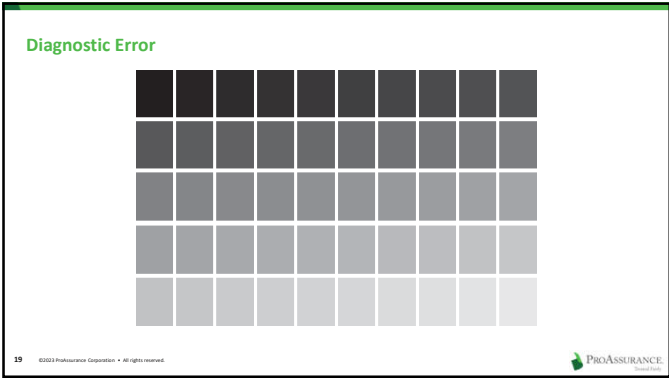
Diagnostic Error



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Diagnostic Error

Closed Claims and Lawsuits 2017 - 2019

Paid to Closed	Average Indemnity	Average Defense Cost
28%	\$455,244	\$82,655

MPL Association Data Sharing Project. Claims closed between 2017 and 2019 with diagnostic error as the primary allegation.

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Diagnostic Error: Communication

Physician-to-Physician Communication

- Strategies for effective handoff communication
 - Establish and document clear expectations with other physicians for follow-up & treatment
 - Include patient in communication of expectations
 - Follow-up with other physicians regarding treatment, when appropriate

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Diagnostic Error: Communication

Physician-to-Physician Communication

- Tracking & follow-up
- Recently discharged patients
- Identify routine vs. emergent communications
 - Emergent communications
 - Contact other physician(s) directly, when appropriate
 - Communicate to other physician through other parties or other means
 - Closing loop in communication
 - Contact patient directly, if necessary

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Diagnostic Error: Communication

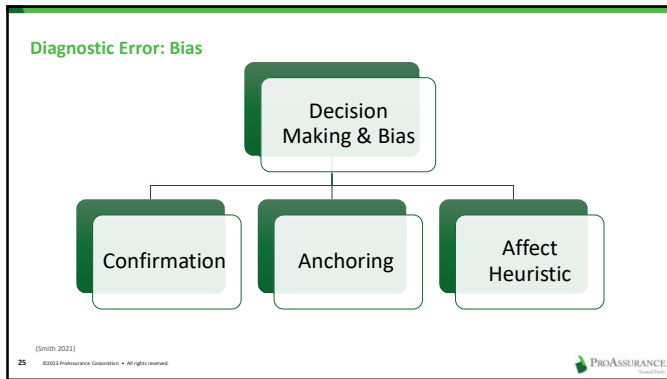
Communication with Patient

- Communicate all results to patient
- Medically indicated care
- Need to follow-up future diagnostic studies and/or procedures

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Diagnostic Error: Bias

- Confirmation
 - Gathering and interpretation of evidence confirming beliefs
 - Not considering alternative diagnosis even though data might contradict initial diagnosis
 - Diagnostic momentum

(Smith, 2021)

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Diagnostic Error: Bias

- Anchoring and premature closure
 - Like confirmation
 - Failure to consider other reasonable alternatives after primary diagnosis is reached
 - Patient presents with LBP
 - Physician attributes cause to patient's personal history of osteoporosis without ruling out other potential causes

(Smith, 2021)

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Diagnostic Error: Bias

- Affect Heuristic
 - Emotional reactions
 - Positive or negative feelings toward patient
 - Patient specific circumstances relevant to diagnosis

(Smith, 2021)

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Diagnostic Error: Follow-up & Communication

Poor communication by physicians & other healthcare professionals can lead to claims and alleged negligence

Miscommunication can lead to medical errors & treatment delays

Failure to follow-up may result in patient harm

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Everyday Risks: Documentation



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Documentation

1 in 5 MPL lawsuits involves a documentation issue

Witness that "never lies or dies"

(Dhaith et al. 2022)

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Documentation

EMR: a multi-use tool

Patient communication

21st Century Cures Act

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Documentation - 2 Minutes: What's the Risk?

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2 MINUTES: What's the Risk?

CURES ACT

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Documentation: Common Areas of Risk


Patient Allergies

Medications

Patient History

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Documentation: Everyday Risks

- Review and documentation of allergies in the medical record
- Update patient history, provider review & document the medical record
- Review and document medications in the medical record, including discontinued prescriptions

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Case Studies



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Documentation: Allergy

- Patient with known contrast dye allergy
- ED physician did not review patient's record
- Relied on CT tech
- Transport tech mentioned possible dye allergy

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Documentation: Allergy

- CT Tech questioned patient
- No further discussion between CT Tech and MD
- Patient given IV contrast dye prior to CT
- Cardiac arrest

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Documentation: Risk Reduction Strategies

- Always review patient allergies
- Patient answers cannot always be trusted
- Keep data and EMR up to date
- Review emergency procedures for patient allergies



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Documentation: Patient History & Medication

- 85 YOF with dementia recovering from cardiac arrest
- Dementia worsened after coming off ventilator
- Patient admitted to hospital
- Treated by internist & psychiatrist
- Ordered to continue all medications

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Documentation: Patient History & Medication

- Nursing home medical director assumed care
- Transferred from hospital to nursing home
- Med. Dir. did not review entire chart
- Case settled prior to trial

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Documentation: Risk Reduction Strategies

- Review and update documentation regularly
- Complete documentation in a timely manner
- Be thorough and accurate
- Use checklists and templates



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Documentation

Poor documentation practices are difficult to defend

Can lead to misunderstandings or errors in patient care

(Ghaith et al. 2022)

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**Everyday Risks:
Informed Consent**



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Informed Consent: Everyday Risk

- Ethical, professional, and legal requirement
- Reduces risk
- Builds rapport and trust with your patient
- Consent form supplements the informed consent process
- Documentation is evidence
- Evidence supports the disclosure discussion

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Informed Consent: Elements

- Physician-patient relationship
- Physician's duty to know the risks/alternatives
- Physician's duty to disclose the risks/alternatives
- Breach of these duties
- Causation
- Harm

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Informed Consent: Baseline Self-Assessment

Areas assessed:

- Provider discusses the risks, benefits, & alternatives of the treatment plan
- Informed consent discussions are documented in medical record
- Procedure-specific informed consent forms for invasive procedures are used
- Informed refusal discussions occur and are documented in medical record

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Informed Consent: Case Study

Allegation: patient would not have consented to surgery if she had known that vagus nerve injury was a known risk.

- Patient history of chronic GERD refractory to medical treatment
- Surgeon referral, laparoscopic fundoplication recommended
- No mention of vagus nerve injury risk in educational materials or consent form
- Risk of vagus nerve injury not disclosed by surgeon

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Informed Consent: Case Study

Brochure

Risks and Complications
Any surgery has risks and complications. For laparoscopic fundoplication, these include:

- Injury to the liver, spleen, esophagus, or stomach during surgery
- Bleeding
- Infection
- Increased gas or bloating
- An inability to vomit
- Difficulty swallowing
- Failure of the operation to completely eliminate GERD

Consent Form

The doctor has explained to me:
The following risks may be involved in this procedure:
Bleeding, infection, difficulty swallowing, persistent reflux, injury to surrounding organs, hernia, death

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Informed Consent: Case Study


- Vagus nerve transection during surgery
- Diagnosis of gastroparesis
- New surgeon recommends fundoplication, with roux-en-y esophagojejunostomy if necessary
- Conversion to esophagojejunostomy due to vagus nerve transection
- Lawsuit alleging negligent surgery and lack of informed consent

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Informed Consent: Case Study

Deposition Testimony



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Informed Consent: Risk Reduction Strategies

- Present risk concepts in terms patients are likely to comprehend
- Do not generalize to a degree that patients cannot conceive of potential adverse outcomes
- Check in with patients to gauge comprehension

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Informed Consent: Risk Reduction Strategy

Consider how the addition of this statement during the consent process might have changed the outcome of lawsuit



Laparoscopic fundoplication can cause damage to the vagus nerve, which can delay stomach emptying. This may require further surgery.

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Informed Consent: Case Study

Allegation: Physician did not discuss the risks of the surgery with the patient

- ENT's PA meets with patient prior to surgery
- Receptionist gives patient several forms, including informed consent form for sinus surgery
- Surgery damages dura mater, necessitating additional surgeries & causing permanent disability
- Patient testifies he would not have consented to surgery, if the surgeon had explained the possibility of dura mater injury & its sequelae
- Jury finds in favor of the patient

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Informed Consent: Case Study

- Informed consent ≠ waiver of physician liability for negligently performed procedures
- Plaintiff patient's acceptance of dura mater injury risk ≠ defendant surgeon's shield from liability for negligent injuries to the dura mater
- Expert testimony:
 - Injuries to the dura mater can occur without negligence
 - Surgeon used excessive force

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Informed Consent: Risk Reduction Strategies

- If multiple individuals are involved, ensure roles align with informed consent laws & medical ethics
- Document informed consent process, including your appropriate role
- Perform gap analysis – is your informed consent process & documentation appropriate?



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Informed Consent: Refusal

- Informed refusal process should mirror informed consent process
- Honoring patients' informed refusals of treatment respects autonomy
- Possible battery: imposing unwanted interventions on a competent patient

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Informed Consent: Recap

- Ethical, professional, & legal requirement
- Informed consent process can reduce liability risk
- Forms & medical record documentation are evidence that risks, benefits, & alternatives of procedure were discussed and agreed to

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Everyday Risks: Services



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Services

- Telemedicine
- In-office sedation
- Pain management

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Telemedicine

How is a telemedicine visit different

- Technology introduces complexity
- Additional layer of informed consent
- Additional confidentiality/security concerns
- Integration
- Limits of not being physically present with patient

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Telemedicine

- Informed Consent
- Nature of telemedicine visit
 - Detailed hx, imaging, testing
- Potential benefits, constraints, risks, and alternatives
 - Exam
 - Technology
- Include patient responsibilities
 - Confidentiality

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Telemedicine

- Informed Consent
- Patient education
 - Inform patients of the availability of telemedicine
 - Explain to patients the limitations
 - Document the discussion of the risks, benefits, and alternatives of telemedicine in the patient's chart
 - Telemedicine platforms useful

[illegible]

This is a sample form to assist you in creating a unique form for your practice. The sample form is in a general format that does not account for varying state laws. Consult your state law to ensure compliance with any state specific informal consent rules and regulations.

Sample Telehealth Informed Consent Form During COVID-19 Pandemic
(Practice Name)

DEFINITION: The Health Resources and Services Administration (HRSA), of the U.S. Department of Health and Human Services (DHHS) defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration. Technologies include videoconferencing, the internet, store- and-forward imaging, streaming media, and landline and wireless communications.

NATURE OF TELEMEDICINE VISIT: During the telemedicine visit, details of your medical history, examinations, imaging and/or testing may be discussed using interactive video, audio, and telecommunications technologies. Telemedicine visits may help limit the spread of contagious diseases, including the Coronavirus (COVID-19).

I understand there are limitations with telemedicine visits, such as being able to conduct physical exams, which may limit my provider's ability to diagnose certain conditions.

I understand that a variety of alternative methods of medical care may be available to me and my healthcare professional has explained the alternatives to my satisfaction and I may choose to opt out of medicine in favor of another appropriate and available method at any time.

I understand that, as with any technology, telemedicine has technology limitations, which may affect my provider's ability to fully complete a telemedicine visit. In the event of technology limitations, I

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During the COVID-19 pandemic, the U.S. Department of Health and Human Services (HHS) has permitted certain telecommunication methods which might not otherwise be permitted. I understand that my healthcare provider will work to maintain the security of information transmitted. It is a practice my communication applications that comply with the FCC's security requirements, a statement to

Due to the healthcare impact of COVID-19, I understand that this telemedicine visit may occur with a

3. **(Name of patient or parent/guardian)**, agree to participate in a telemedicine visit and authorize the

electronic transmission of my medical information and in video conferencing session. By signing this form, I acknowledge I have read and fully understand the above information.

Patient Signature (or Signature of Person Completing Form if Not Patient) _____ Date _____

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other: _____

Physician Signature _____ Date _____

Telemedicine

- Medical Professional Liability Concerns
- Patient selection
 - Not all presentations can be treated remotely
 - Appropriate clinical context
 - Older adult challenges
 - Access to computer, high speed internet, not using on a regular basis
 - Difficulty hearing, seeing, speaking, and being understood

Telemedicine

- Medical Professional Liability Concerns
- Patient training
 - What to expect
 - Consent
 - Confidentiality
- Track outcomes
 - Platform may have quality measures built in
- Implementation and monitoring
 - Eligible providers
 - Regulatory and legal

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Telemedicine

- Medical Professional Liability Concerns
- Documentation
 - Each and every telemedicine visit is charted
 - Type of visit is clear
 - Complete and accurate
 - Originating and distant sites are identified
 - Verbal consent or e-consent via telemedicine platform
 - Importance of follow-up as appropriate
 - Consultations and referrals

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Telemedicine

- Big Takeaways
 - Many things have changed, some have not
 - Standard of care, informed consent, and documentation requirements
 - Dual regulatory structure- federal and state
 - Technology introduces complications
 - Plan accordingly
 - Informed consent
 - Ongoing telemedicine changes

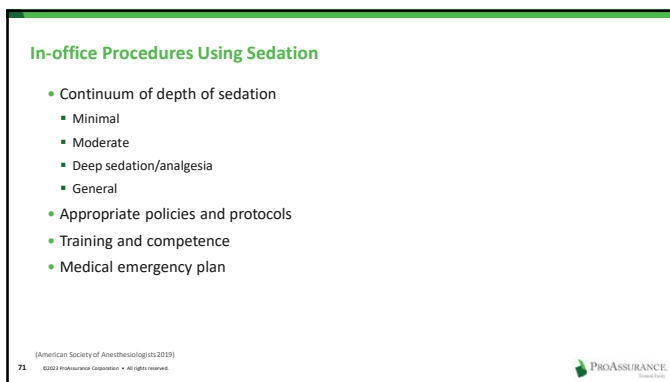
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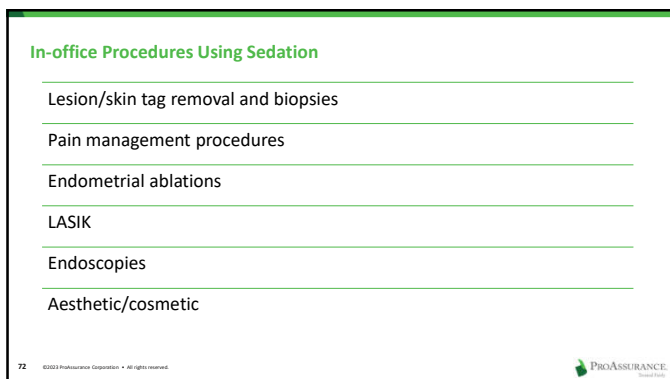
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In-office Procedures Using Sedation

- Patient identification procedure
 - Verification or timeout to prevent wrong patient and procedure
- Moderate sedation requires pre-operative history & physical
- Monitoring pre/intra/post procedure
 - Vitals, SaO₂, EKG (if applicable)
- Written discharge instructions provided
- Follow-up phone call

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In-office Procedures Using Sedation

Office-based surgical pre-procedure checklist

Patient Name _____ DOB ____/____/____ Date ____/____/____ a.m./p.m.
 Diagnosis _____ Procedure _____ Time _____
 Surgeon _____ Advanced Directive ☐ Yes ☐ No
 Copy On File ☐ Yes ☐ No

Pre-Procedure Checklist (Complete prior to transporting patient to procedure/surgery area)				Comments:
Yes	No	N/A		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History and physical on record	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laboratory studies on record	Test(s) Completed:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiologic studies on record	Test(s) Completed:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EKG on record	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other tests on record	Identify:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NPO	Date/time last intake: Solids @ _____ Liquids @ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Procedure consent signed by patient	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Procedure consent signed by surgeon	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient identified (2 identifiers), ID band on	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (e.g. drugs, latex, food)	List:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Voided	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin integrity intact	

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In-office Procedures Requiring Sedation

Minor surgery monitoring flow sheet and intro-procedure checklist

Patient name: _____ Procedure: _____
 Date & Start Time: _____ Date & End Time: _____
 Surgeon: _____ Assistant(s): _____
 Time out completed: ☐ Yes ☐ No Init. _____ Other: _____
 Q 5 Minutes

Time	B/P	Pulse	Resp.	SaO ₂	Cardiac Rhythm	LOC	Pain 0-10	Medication/Dosage	Staff Initials

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In-office Procedures Requiring Sedation

Office-based post anesthesia recovery record

Patient Name: _____ Date of Birth: ____/____/____ Date: ____/____/____

Time In: _____ Time discharged from Recovery: _____ Time discharged from Facility: _____

Type of Anesthesia: ☐ GA ☐ MAC ☐ Block ☐ IV Regional ☐ Spinal ☐ Epidural ☐ Local ☐ Other _____

Time	B/P	Pulse	HR	SpO2	O2 Mask/ N/C/ Room Air	ECG	Temp	Post Anesthesia Recovery Score		Time
								IN	OUT	
								Activity	1	
								Can bear hand grasp, moves all four limbs	2	
								When hand grasp, no flex. movement	1	
								Extremities	0	
								No movement to command	0	
								Strong breath, vocal effort	2	
								Disperses, or min. resp. effort	1	
								Spont. resp. or post-anesthetic	0	
								Spont. resp. or post-anesthetic	0	
								BP = 100% of pre-anesthetic	1	
								BP = 100% of pre-anesthetic	0	
								Consciousness	2	
								Alert and oriented	1	
								Not responding	0	
								By R. reflex or	2	
								accus. unresponsive, then	1	
								Wet vomit, pink, red, or white vomit	1	
								Excessive bleeding requiring	0	
								intervention by physician	2	
								No pain or need for operative anal.	2	
								Defined pain in operative or	1	
								unoperated site	0	
								No pain, uncontrollable pain	2	
								Not compliant in sign of vertigo	1	
								N/A, no patient vomiting uncontrolled	1	
								Retching and vomiting uncontrolled	0	

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Pain Management



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Pain Management: Opioid Epidemic Continues

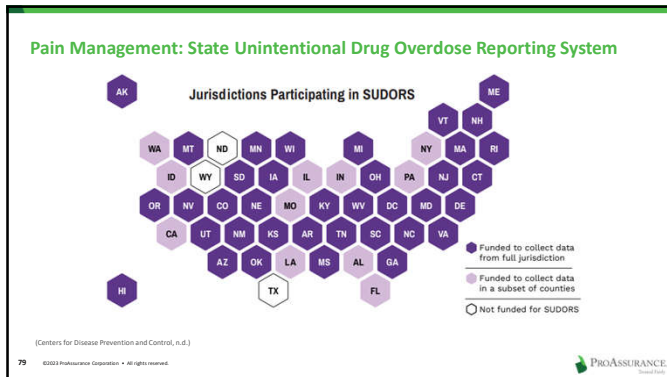
- Overdose deaths remain leading cause of injury-related death in U.S.
- Every drug overdose death, many more nonfatal
- Coordination of data
 - Health department
 - Community
 - Healthcare providers
 - Public health
 - Law enforcement
 - Government agencies

(Centers for Disease Prevention and Control, n.d.)

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Pain Management: Case Study

- 33 YOF with history of heavy smoking, anxiety, chronic pain due to trauma
- Initially patient is evaluated as low risk
- History and polypharmacy patient at high risk for medication abuse
 - Proper monitoring required
 - Tolerance issues identified resulting in tapering
 - Breakthrough pain identified

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Pain Management: Case Study

- Patient signs pain agreement
- New injuries reported periodically resulting in increase and adjustment in dosages
- Physician observes aberrant behavior
 - Requires monthly pill counts and random urine screens
 - Behavior continues, patient requests refills early
 - Drug screen reveals benzodiazepine (not prescribed)

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Pain Management: Case Study

- Patient continues to resist tapering
- Physician advises patient switching to suboxone and discontinue opioids
- Pharmacy reports patient attempts to refill oxycontin prescription
- Physician writes a referral to another pain clinic

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Pain Management: Case Study

Allegations

- Over-prescription of opioids
- Necessitated rehab/detox programs to address addiction
- Loss of relationships with children

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Pain Management

Risks associated with opioid management

- Non-compliance with federal/state guidelines
- Allegations of over-prescribing
 - Failure to recognize misuse/dependence
 - Board sanctions
 - Potential legal claim
 - Civil
 - Federal (DEA)

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Pain Management

Mitigation strategies opioid misuse

- Screening tools
- New patient checklist/questionnaire
 - Release of information
 - Careful review of past records
- Prescription Drug Monitoring Program (PDMP)
- Drug screening
- Physician-patient agreement
- Ongoing communication is key

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Pain Management

Initial encounter

- Non-pharmacologic treatment initially
 - As appropriate
- Reinforce frequency of assessment, monitoring, & testing
- Opioid maintenance therapy
 - Informed consent/pt. education
 - Pain contract outlining conditions for prescribing
- Schedule follow-up visits before patient leaves office

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Pain Management

Practice management techniques

- Thorough history & exam
 - Obtain past medical records
- Clear communication regarding expectations
 - Pain agreement
- Documentation
 - Diagnostic and therapeutic rationale
 - Development and length of treatment plan
 - Goals during and at end of plan
 - Referrals to subsequent treaters
 - Patient education

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Pain Management

Practice management techniques

- Opioid management policy/process
 - Uniform practice
 - Standardized management
 - Reduce liability
- Quality improvement/medical record review

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Everyday Risks: Additional Topics



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Additional Topics

- Infection prevention
- Scheduling/communication
- Emergency preparedness
- Staff training
- Culture

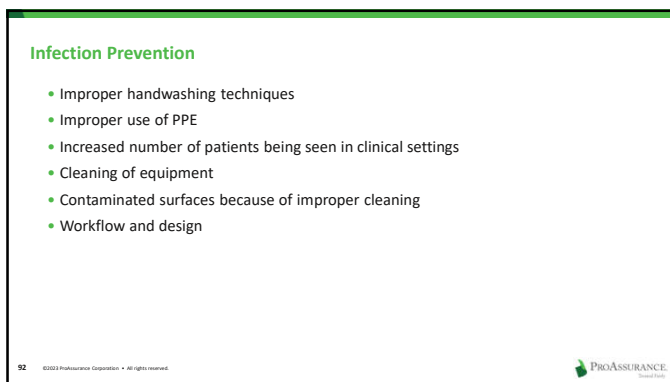
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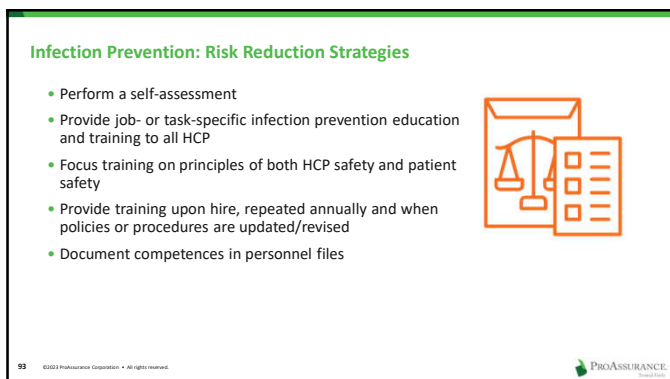
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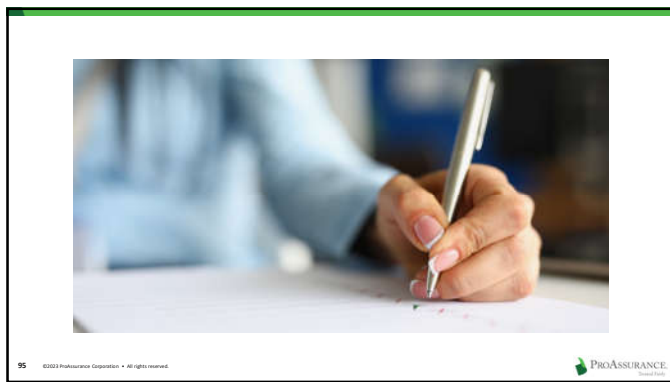
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Scheduling & Communication: Risk Reduction Strategies

- Establish a tracking system for all missed or cancelled appointments
- Document follow-up attempts to reschedule appointments or referrals
- Verify patient contact information with each encounter
- Notify physician when patients miss appointments or referrals
- Establish a reminder system for patient's appointment



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**Everyday Risks:
Emergency Preparedness**



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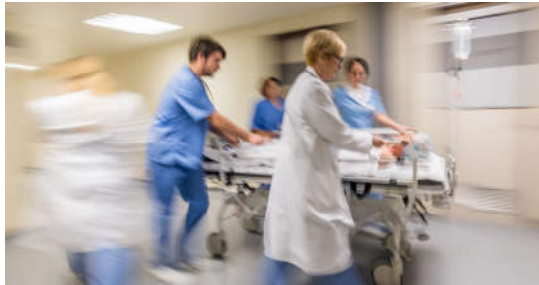
Emergency Preparedness

- Patients have a variety of co-morbidities
- Patient can present with an emergency
- Anaphylaxis after treatment
- Being prepared to manage issues will ensure patients receive the best care in a timely fashion

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Emergency Preparedness: Risk Reduction Strategies

- Staff BLS certified
- Emergency equipment available
- Plan of action
- Practice



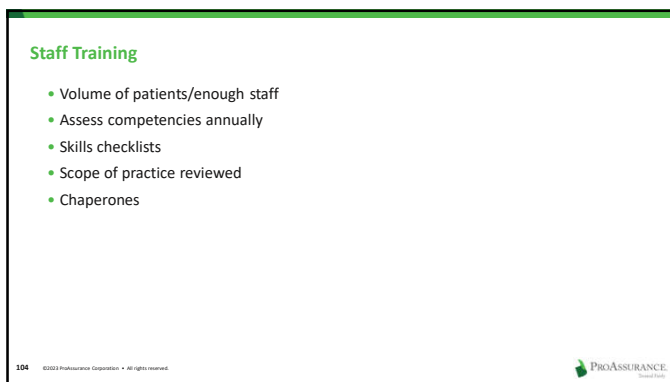
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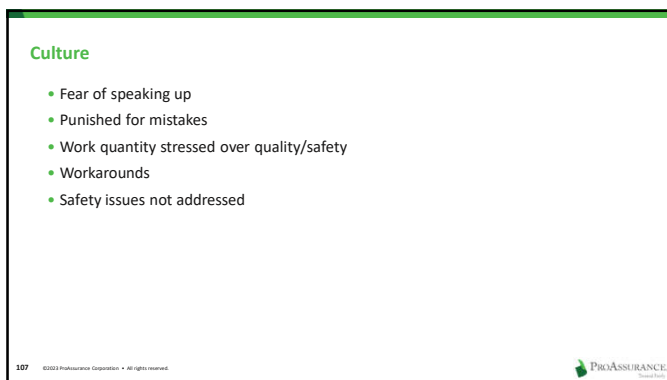
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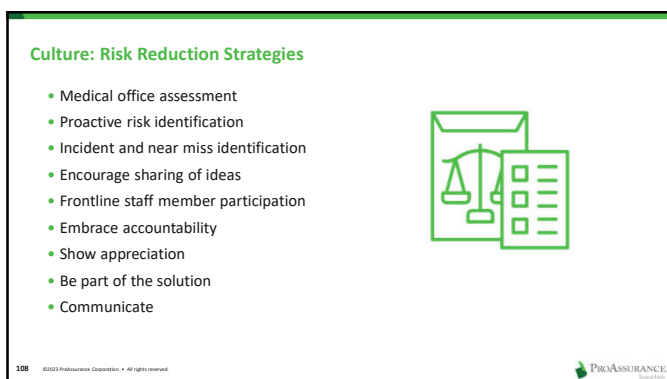
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Additional Topics


- Infection prevention
- Scheduling/communication
- Emergency preparedness
- Staff training
- Culture

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**Everyday Risks:
Benchmark Your
Practice**




Aaron Hamming, Esq., CPHRM
Data & Technology Manager




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Identifying & Addressing Your Practice's Unique Risks

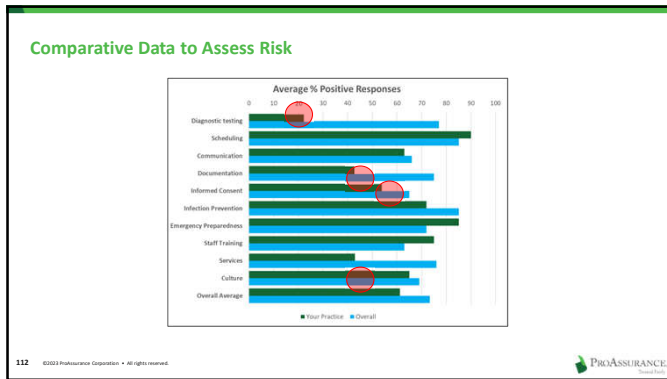
- Online survey
- Available to all staff members
- Finished in a few minutes
- Answers collected anonymously
- Results aggregated for practice overview
- Comparison & benchmarks part of feedback report



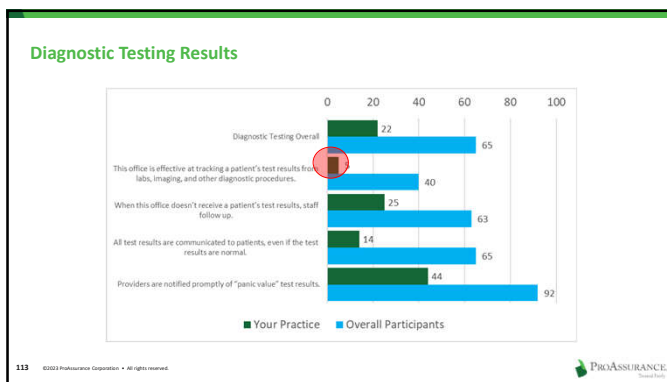
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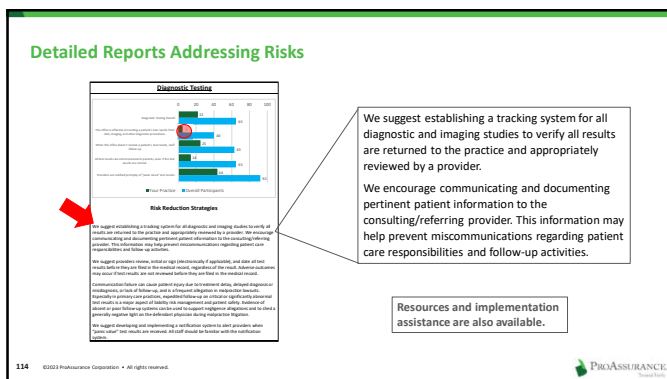
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Innovative Baseline Self-assessment

- Available to use in 2023
- Potential for premium credit in 2024
- Targets common areas of risk
- Detailed report specific
- Risk reduction strategies
- Targeted risk interventions
- Resources to address areas of concern



ANALYSIS

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ProAssurance Risk Management Services

When combined with other ProAssurance services, you can:

- ASSESS**
- UNDERSTAND**
- ADVISE**

How to stay proactive, better understand your risks and make informed decisions about the right coverage for the right price.

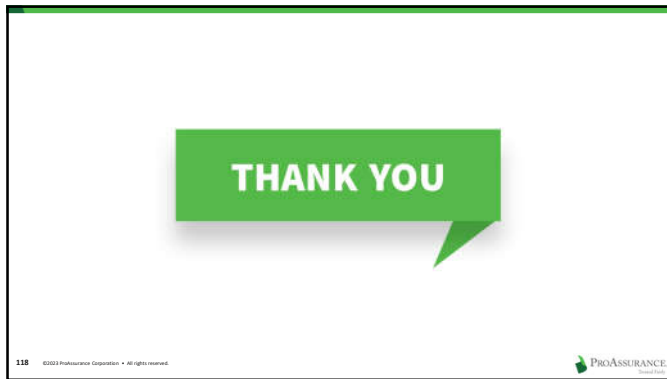
For more information, visit www.proassurance.com/riskmanagement or call 800-447-7623.

RiskAdvisor@ProAssurance.com

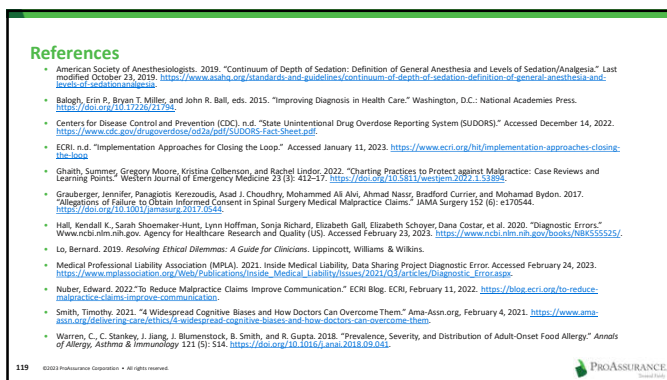
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