ASC Risk Management Trends

NYSAASC Fall Conference
Disclaimer

Information in this presentation is neither an official statement of position nor should it be considered professional legal advice to individuals or organizations.
Objectives

Participation in this seminar will better enable learners to:

• **Discuss** the leading claim allegations involving ASC healthcare professionals;

• **Identify** the most common risks identified during an onsite risk management assessment; and

• **Establish** a framework that promotes practical & applicable loss prevention strategies to address those risks.
Study the Data

“When you can measure what you are speaking about, and express it in numbers, you know something about it; but when you cannot measure it, when you cannot express it in numbers, your knowledge of it is of a meager and unsatisfactory kind; it may be the beginning of knowledge, but you have scarcely, in your thoughts, advanced it to the stage of science.”

-Sir William Thompson, Lord Kelvin (1824-1907)
The Future of Physician Liability
Physician Insurers Association of America (PIAA)

- Cumulative Study dates back to 1985
  - National private practice physicians
  - Dentists
  - Nurses/NP
  - Other healthcare professionals & organizations
- Credible database for claims

Source: PIAA Closed Claim Comparative – 2015 Edition
### Average Indemnity by Specialty (2005-2014)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Average Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>$450,631</td>
</tr>
<tr>
<td>Obstetric and Gynecologic Surgery</td>
<td>$423,250</td>
</tr>
<tr>
<td>Neurology - nonsurgical</td>
<td>$418,449</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$397,407</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>$381,840</td>
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<tr>
<td>Radiology</td>
<td>$360,397</td>
</tr>
<tr>
<td>Pathology</td>
<td>$347,856</td>
</tr>
<tr>
<td><strong>Internal Medicine</strong></td>
<td><strong>$341,925</strong></td>
</tr>
<tr>
<td><strong>Emergency Medicine</strong></td>
<td><strong>$336,155</strong></td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td><strong>$332,540</strong></td>
</tr>
<tr>
<td><strong>All Specialties</strong></td>
<td><strong>$330,940</strong></td>
</tr>
<tr>
<td><strong>Urologic Surgery</strong></td>
<td><strong>$328,432</strong></td>
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<tr>
<td><strong>Cardiovascular and Thoracic Surgery</strong></td>
<td><strong>$324,777</strong></td>
</tr>
<tr>
<td><strong>General Surgery</strong></td>
<td><strong>$321,039</strong></td>
</tr>
<tr>
<td><strong>Ophthalmology</strong></td>
<td><strong>$276,013</strong></td>
</tr>
<tr>
<td><strong>Orthopedic Surgery</strong></td>
<td><strong>$266,832</strong></td>
</tr>
<tr>
<td><strong>Cardiovascular Disease - nonsurgical</strong></td>
<td><strong>$242,241</strong></td>
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<tr>
<td><strong>Dermatology</strong></td>
<td><strong>$231,950</strong></td>
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<td><strong>Psychiatry</strong></td>
<td><strong>$200,722</strong></td>
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<tr>
<td><strong>Plastic Surgery</strong></td>
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<tr>
<td><strong>Oral Surgery</strong></td>
<td><strong>$104,347</strong></td>
</tr>
<tr>
<td><strong>Resident/Intern</strong></td>
<td><strong>$87,500</strong></td>
</tr>
<tr>
<td><strong>Dentists</strong></td>
<td><strong>$71,112</strong></td>
</tr>
</tbody>
</table>

Reprinted with permission from the PIAA MPL Closed Claim Comparative, 2015 Edition, Exhibit 2, Copyright 2016. The information provided may be used for personal use only. Any other use requires prior permission of PIAA.
Nature of the Lawsuit

- Failure to diagnose: 31%
- Patient suffered an abnormal injury: 31%
- Failure to treat: 12%
- Poor documentation of Pt instruction & education: 4%
- Errors in medication administration: 4%
- Failure to follow safety procedures: 3%
- Improperly obtaining/lack of informed consent: 3%

The “Experience” of Being Sued

- Horrible; one of the worst experiences of my life: 37% (Men), 26% (Women)
- Very bad; disruptive and humiliating: 36% (Men), 20% (Women)
- Upsetting, but I was able to function: 33% (Men), 20% (Women)
- Unpleasant and irritating, but I've had other equally unpleasant experiences: 14% (Men), 8% (Women)
- Neutral: 2% (Men), 1% (Women)
- Not as bad as I thought it would be: 1% (Men), 1% (Women)

### Location of Surgery Claims

- **Hospital** 80.0%
- **Physician’s office** 9.2%
- **Hospital outpatient facility** 4.5%
- **Surgery center** 2.2%
- **Other** 8.0%

Source: MPL Specialty Specific Series – 2015 Edition
Claim Payment Analysis
Combined Specialties

2005 - 2014

• 28 specialties by claims reported
• Average indemnity pd. $360,653
• Average expenses pd. $47,261

• Largest claim
  – OB/Gyn 13M

Source: PIIA Closed Claim Comparative – 2015 Edition
Malpractice: Then & Now Pd. Closed Claims – Combined Specialties

<table>
<thead>
<tr>
<th></th>
<th>2005-2009</th>
<th>2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Indemnity</td>
<td>$375,920</td>
<td>$346,451</td>
</tr>
<tr>
<td>Average Expenses</td>
<td>$42,914</td>
<td>$51,333</td>
</tr>
</tbody>
</table>

Source: PIAA Closed Claim Comparative – 2015 Edition
Claims Closed With & Without Indemnity Combines Specialties – 2004 - 2013

35% Claims Closed with Indemnity
65% Claims Closed without Indemnity

Source: PIAA MPL specialty Specific Series – 2014 Edition
Most Frequent Allegations
Combined Specialties – 2009 - 2014

• Errors in diagnosis
• Failure to recognize complication from tx
• Improper performance
• Failure to monitor case
• No medical misadventure

Source: PIAA Closed Claim Comparative - 2015 Edition
Top Allegations (2005-2014)

- Improper performance
- Errors in diagnosis
- No medical misadventure
  - Medical legal issues
- Failure to supervise/monitor case
- Failure to recognize complication of treatment

PIAA Closed Claims Comparative: A comprehensive analysis of medical professional liability data reported to the PIAA Data Sharing Project. 2015 Edition.
Defining Risk Management

• “Identification, classification, & prioritization of risks…”
• “Coordinated & systematic application of resources…”
• Mitigate, monitor & control probability and/or impact of unfortunate events
Defining Risk Management

- Prevent lawsuits
- Increase defensibility
Why Do ASCs Get Sued?

• No single explanation
• Variety of factors
• Complicated situations
• Involves some adverse event
Assessment
ASC Site Assessment

- Identify, assess, manage & mitigate risks
  - Systematic, multi-disciplinary approach
  - Determine the most effective, practical, and applicable approach to manage risks
  - Monitor the effectiveness of efforts
ASC Site Assessment
ASC Site Survey – What We Look At

- Anesthesia and surgery
- Medication administration
- Medical staff and nursing profiles
- Medical record documentation
- Effective communication
ASC Site Survey – What We Look At (cont’d)

• Quality Improvement
• Risk Management
• Competency
• Information Management
• Systems
  – Codes
  – Biomedical/Safety
Next Steps

- Identify problem areas
- Prioritize
- Suggest changes/improvements
- Monitor
How Do The Findings Stack Up?
Coming in at 58% ... Anesthesia

- Documentation of pre-anesthesia exam
- Pre-anesthesia exam for pts receiving moderate sedation
Pre-Anesthesia Documentation

• Most frequently missed criteria
  – Patient’s previous hx
    ▪ Anesthesia
    ▪ Allergies
    ▪ OTC, herbal, vitamins
    ▪ Alcohol/substance abuse
    ▪ Sleep apnea
    ▪ ASA – determination of appropriate cases
Pre-Anesthesia Documentation

- Most frequently missed criteria (con’t)
  - Review of systems
  - Description of teeth
  - DX testing not reviewed
  - Basic exam
  - Anesthesia plan
  - Pt. agrees and understands

- Blanks on templates
And then at 53% … Systems

- Semiannual mock codes are not performed
  - Cardio/respiratory
  - Malignant hyperthermia
  - OR fires

- Crash cart checks & logs
  - Frequency
  - Location
At 47% ... Competency

- Competencies documented evidence demonstrating
  - Pediatric medication administration
    - Pharmacy conversion test is completed annually
    - Passing score is 100%
  - Emergency medical equipment
  - OR fires
At 45% ... Competency

- Staff education re impaired/disruptive behavior
  - New employees receive education regarding S/S of impaired/disruptive behavior
  - Employees receive annual updates
  - Education process includes system for reporting staff
    - Chain of command
Then at 42% ... Systems

- Impound equipment involved in pt injury
- Criteria
  - Policy specifies immediate notification
    - Involves pt injury
    - Equipment not released for inspection or repair by mfr w/o administration approval
At 42% ... Quality

- QA minutes & quality documents are clearly labeled with appropriate protective language

- Criteria
  - Separation of QA & business minutes
  - QA minutes are labeled according to state’s quality assurance statutes
  - Peer review information in credentialing file
Peer Review/Quality Assurance

- Peer review is performed in variety of settings, e.g., part of QA program
- Promote candor & confidentiality in peer review process, & foster aggressive critique of medical care
Federal Statute

- Health Care Quality Improvement Act
  - Purpose: improve quality of care
- Physician peer review
- Protects reviewers from legal action if fair & reasonable review

Peer Review Protections

  “None of the records, documentation, or committee actions or records required . . . nor any incident reporting requirements imposed upon diagnostic and treatment centers pursuant to the provisions of this chapter shall be subject to disclosure. . . .”
Peer Review Protections (cont)

• See also id. at §6527 (3)

“Neither the proceedings nor the records relating to performance of a medical or a quality assurance review function or participation in a medical and dental malpractice prevention program nor any report required by the department of health [...] shall be subject to disclosure [...]. The prohibition relating to discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting.”
Steps in Risk Management

• All reports go to peer review committee
• Direct reports to appropriate peer review committee member
• Evaluate all reports as agent of peer review committee
• Modify policies to accurately define procedures outlined in your state’s statute
Steps in Risk Mgmt (cont’d)

• Clearly label with appropriate protective language
• Educate staff
  – Broad reach of peer review protections & requirements to obtain & maintain protection
Confidentiality Statement

- At a minimum:
  - Privileged pursuant to [state] Statute § ______
At 40% … Medical Record Documentation

- Surgical H&P incomplete
  - >30 days
- Informed consent
  - AMA
- Pre-post operative RN templates blank
  - Vitals
  - Education
  - Responsible adult
eye irritation thur fri became worse light sensitivity
on one of your patients, do you expect other physicians or health care providers or anyone to question the accuracy of your findings, or do you expect them to take you at your words?

A If I dictate it promptly.

Q If you dictate it at any time?

A If I dictate it a month and a half later, I would say that they would have a legitimate right to question how good my memory was a month and a half later with regard to details.

Q So do you dispute that Dr. found no dead or necrotic tissue when he operated on the morning of

A I find that extremely surprising.
Documentation for Discharge

• Condition upon discharge
• Instructions understood and repeated
• Contact number if questions post discharge
• Conditions under which to call
  – Contact information
• Follow-up care
  – Appointments
  – Outstanding labs, tests
Documentation for Discharge

- Response to medication
- Level of distress
- Method of departure
- Name of escort
Documentation for Discharge

- Safety restrictions
  - Driving
  - Machinery
- Patient valuables
- Discharge instructions handed to patient
Communication at Discharge: Last Chance to “get it right”

• “Do you have any other questions?”
• “Can we do anything else for you?”
• “Do you have any questions about how to take of your __________.”
• Do you know what to do if there are problems?
• Do you know what problems to look for?
At 40% … Medical Record Documentation (con’t)

• Post operative monitoring
  – > 24 hours
  – On call situations
    ▪ Anesthesia and pain related issues

• Time outs
  – Site verification
Document the care you were trained to provide
Retained Foreign Bodies

• Surgical Instruments, Sharps & Sponge Counts
  – Count procedure performed same way for every case
  – Count when personnel change made during procedure
  – Surgical towels should not be used as sponges
Wrong Site Surgery
Case Study
Case Study

- 50 YOWF (5’6”, 230 lbs.)
- Chronic R knee pain
  - Conservative treatment recommended
- 2 Months later
  - Advanced R knee degeneration
  - Total knee arthroplasty recommended & scheduled
Case Study (cont’d)

- Pt marked surgical site with “S”
- TED hose placed on R leg
- Pt transferred to OR
- “Time Out” conducted
- L leg prepped & draped for surgery
Case Study (cont’d)

- Surgeon marked leg for incision
- L knee opened & retracted
- Surgeon reviewed x-ray
- Surgeon broke scrub to talk to family
- L knee closed
- R knee arthroplasty performed
Case Study

- Although the form was completed, surgical team failed to conduct the process as it was intended.
Mark Hakim
Risk Management Director, ProAssurance


Normalization of Deviance

The accumulated acceptance of cutting corners or making work-arounds over time.

Murphy’s Law is Wrong!

What can go wrong usually goes right, and over time we come to think a safety threat does not exist or is not as bad.

- Sydney Decker
Normalization of Deviance

Before the Challenger explosion there were
9 O-ring failures reported

Before the Columbia explosion there were
7 foam strikes reported
Two Ends of Safety

Blunt End

Sharp End
Flirting With The Margin

Original Boundary Of Acceptable Behavior

1. Normal conditions taken operating point beyond margin

2. Repeated shifts without error – margin redefined

3. Corrective action taken

4. New acceptable operating point

Deviation in OR Setting

- Time outs
- Drug interaction alerts
- Informed consent discussions
- Medication administration
- Patient identification procedures
- Allergy verification
- Hand washing
- YOUR OR issue:__________
Back to Basics: Checklists

• Simple
• Low-tech
• Used routinely in ORs
• Recognition & acceptance in medicine

Risk Management
Program Elements

- Assessment of organization’s needs
- Organizational chart
- Formal written plan
- Implementation of risk management P & P
- Evaluation of program
Program Assessment

• Reporting structure
  – Including committee structure

• Appropriate resources available

• Established channels
  – Quality, Safety, & HR
Program assessment (cont’d)

- Depends on organization’s needs
  - Patient care related risks
  - Medical staff related risks
  - Employee related risks
  - Property related risks
  - Financial risks
Program Support

- Governing Board
- CEO, CFO, CMO
- ASC Administrator
- Nurse Manager
  - Infection control
- Safety Officer
- Patient Representative
- Corporate Compliance Officer
Reporting Risks

- Governing Board
  - Summary of deviations
    - AAAHC/TJC standards
  - Summary of occurrences
  - Corrective actions
  - Results of corrective actions
  - Current risk management issues
Items of Interest

• Governing Board interests
  – Minimizing financial losses
  – Improving/maintaining organization’s reputation
  – Improving/maintaining quality of patient care
  – Patient safety initiatives
Medical Staff Reporting

- Medical staff education
  - Role in risk management activities
  - Partners with organization
  - Cooperation is a win-win situation
  - Appropriate contact information
  - Medical record jousting
  - Impaired colleagues
  - Do-not-resuscitate orders
  - Informed consent & informed refusal
  - Transfer to hospital
Patient Safety

• Medical staff interests
  – Claims frequency/severity & impact on quality of care
  – Clinical risk management issues
Manual Procedures

- Incident Reporting
- Patient Complaints
- Attorney Contact
- Informed Consent
- Sponge/Needle Counts
- Visitor Injuries
- Employee Injuries
- Records Retention

- Body Mechanics
- Sharps Safety/Disposal
- Preventive Maintenance
- Loaner/Defective Equipment
- Patient Triage & Transfer
- Telephone Advice
Verbal Communication

- Communication - #1 root cause of multiple Sentinel Events
- Develop formal channels of communication such as SBAR.
- Repeat & verify information provided verbally.
  - Limit the use of verbal orders.
Competency

- Used in litigation to prove or disprove a claim
- Applies to everyone in an organization
Competency (cont)

- Especially critical in surgical cases
- How many procedures are enough?
- When do you know enough to be competent?
- How do you demonstrate competency?
Competency Wrap-Up

- Documentation of training critical
  - Residency, fellowships, new procedures & equipment

- Evaluating skill sets
  - Honest evaluation
  - Operate with assistance when appropriate

- Informed consent
  - Discuss & document risks, benefits & alternatives w/ pt
  - Discuss your experience & use of assistants
Demonstrating Competence

- Maintain personnel files
  - Reference checks
  - Educational degrees
  - Licenses, certifications
  - Skills checklists
  - Ongoing training
  - Job descriptions

- Performance appraisals
Recommendations

- Initial competency training & verification
- Annual competency assessment
- Specialized training (ex: fetal monitoring skills)
- Mock drills in areas with limited critical events
- Annual pediatric medication tests
- Handling of poor performers (ex: mentoring or terminating)
Mini-Max Principal

The lowest level of performance by any employee, allowed to continue without corrective action, becomes the highest level of performance that can be required of any other employee in a similar position with the employer.

Nelson R. Re-orient your practice from thinking “patient” to thinking “consumer.” Presented at: ProAssurance Risk Resource conference; February 17, 2015; Tucson, AZ.
First Points of Contact

• Can they multitask successfully without getting angry or frustrated easily?

• Are they able to actively listen to people, i.e. do they take the time? Are they defensively preparing responses before hearing the issue? Do they care about your client population?

• Do conditions enable staff to work easily & efficiently?

• What staff are located in the front? What staff are located in the back?

Nelson R. Re-orient your practice from thinking “patient” to thinking “consumer.” Presented at: ProAssurance Risk Resource conference; February 17, 2015; Tucson, AZ.
Thank you for participating in this Seminar