# Top Ten Issues in Patient Safety and Risk Management 2020

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**CMO**
**COPIC**



***I have no conflicts and nothing to disclose***



## LEARNING OBJECTIVES

**At the end of this activity, participants should be able to:**

- Associate and Describe different facets of communication which leads to liability claims or patient safety breaches; including EHR's, informed consent, and radiologist clinician communication.
- Appraise and synthesize the experience of communication and resolution programs, particularly the experience of the COPIC 3R's program.
- Recognize and evaluate certain problem areas; including high dose opioid patients, difficult patients and noncompliance.
- Review and summarize current high risk clinical areas such as acute neurologic conditions.

## LEVELS OF EVIDENCE

There are 3 Levels of Evidence for CME presentations:

1. Evidence mainly from randomized or non-randomized, well designed controlled trials; well-designed cohort or case-controlled analytic studies.
2. **Evidence from multiple studies with or without the intervention being targeted, meta-analysis, opinions of respected authorities or expert panels, or information based on case reports.**
3. Uncontrolled experiments, descriptive studies, presenter's clinical experience/opinion or research in progress.

The majority of this presentation will be based on **Level 2** Evidence.

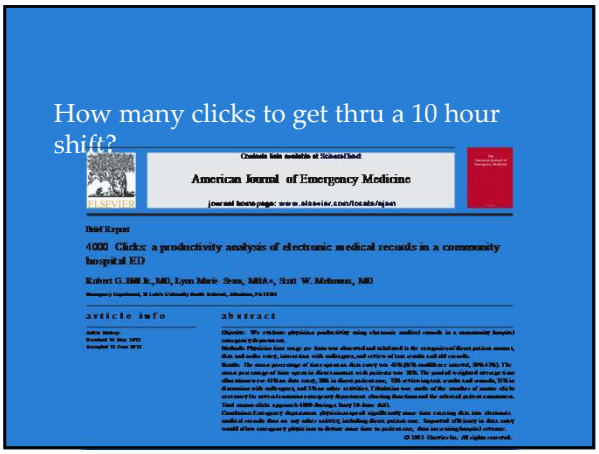
**Malpractice Claims Analysis Confirms Risks in EHRs**

By Debra Bradley Ruder

The number of mouse clicks an ED physician made in an observed 10 hour shift

(answer within 10% please)

How many clicks to get thru a 10 hour shift?



Contents lists available at ScienceDirect

American Journal of Emergency Medicine

journal homepage: www.ajemjournal.com

Brief Report

4000 Clicks: a productivity analysis of electronic medical records in a community hospital ED

Robert G. Hill Jr., MD, Lyn Marie Sears, MBA, Scott W. Melanson, MD

article info

abstract

SORRY

DOES NOT WORK

SORRY

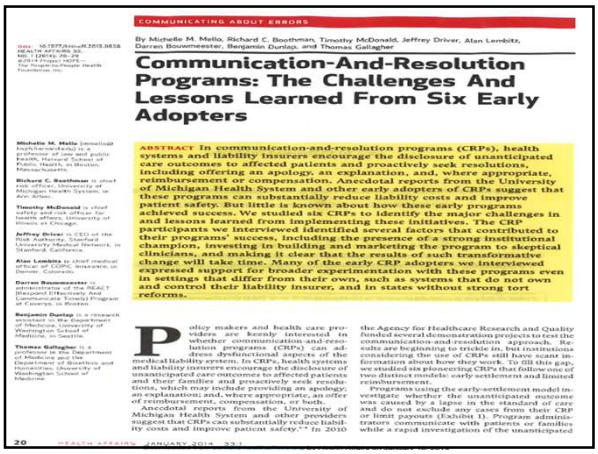
TRANSPARENCY

ACCOUNTABILITY

RESPONSIBILITY

PREVENTIVE ACTIONS

DOES WORK



COMMUNICATING ABOUT ERRORS

By Michelle M. Mello, Richard C. Boothman, Timothy McDonald, Jeffrey Driver, Alan Lembitz, Darren Bouwmeester, Benjamin Dunlop, and Thomas Gallagher

## Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters

ABSTRACT In communication-and-resolution programs (CRPs), health systems and liability insurers encourage the disclosure of unanticipated care outcomes to affected patients and proactively seek resolutions, including offering an apology, an explanation, and, where appropriate, reimbursement or compensation. Anecdotal reports from the University of Michigan Health System and other early adopters of CRPs suggest that these programs can substantially reduce liability costs and improve patient safety. But little is known about how these early programs achieved success. We studied six CRPs to identify the major challenges in and lessons learned from implementing these initiatives. The CRP participants we interviewed identified several factors that contributed to their programs' success, including the presence of a strong institutional champion, investing in building and marketing the program to skeptical clinicians, and making it clear that the results of such transformative change will take time. Many of the early CRP adopters we interviewed expressed support for broader experimentation with these programs even in settings that differ from their own, such as systems that do not own and control their liability insurer, and in states without strong tort reforms.

Policy makers and health care providers are keenly interested in whether communication-and-resolution programs (CRPs) can address dysfunctional aspects of the medical liability system. In CRPs, health systems and liability insurers encourage the disclosure of unanticipated care outcomes to affected patients and their families and proactively seek resolutions, which may include providing an apology; an explanation; and, where appropriate, an offer of reimbursement, compensation, or both.

Anecdotal reports from the University of Michigan Health System and other providers suggest that CRPs can substantially reduce liability costs and improve patient safety.[1,2] In 2010 the Agency for Healthcare Research and Quality funded several demonstration projects to test the communication-and-resolution approach. Results are beginning to trickle in, but institutions considering the use of CRPs still have scant information about how they work. To fill this gap, we studied six pioneering CRPs that follow one of two distinct models: early settlement and limited reimbursement.

Programs using the early-settlement model investigate whether the unanticipated outcome was caused by a lapse in the standard of care and do not exclude any cases from their CRP or limit payouts (Exhibit 1). Program administrators communicate with patients or families while a rapid investigation of the unanticipated



### 3Rs

not negligence based, but adverse outcome has to be due to medical/surgical care. Not reportable to NPDB, CMB. No attorney involved. Reimbursement up to $50K out of pocket costs, no pain and suffering, no liens. Medicare does not recognize this program.

## 3Rs and Candor

### Candor

a new CO and existing IA law that allows for hospitals and providers to have confidential discussions and to determine if compensation is warranted. Attorneys can be involved. No written demands, not a formal claim. Compensation under the program is not reportable to state licensing board or NPDB, but is subject to liens. Medicare reportable and eligible.

## 3Rs and Candor

# CRP Challenges

- Early event reporting
- Inertia
- Diversity of Insurers
- Attorneys
- NPDB and licensing board reporting

**CT ABD/PELVIS W CONTRAST** Status: **Final result**

**PACS Images**

Show images for CT ABD/PELVIS W CONTRAST

**Study Result**

**Result Impression** IMPRESSION:

Normal contrast-enhanced CT scan of the abdomen and pelvis.

CLINICAL INDICATION FOR STUDY:

pt states abd pain and nausea x 1 week; denies injury; no prior surg;

abdominal pain

TECHNICAL DATA:

CT images were obtained from the inferior aspect of the thoraces to the symphysis pubis with oral and intravenous contrast reconstructed in the axial, coronal and sagittal imaging planes.

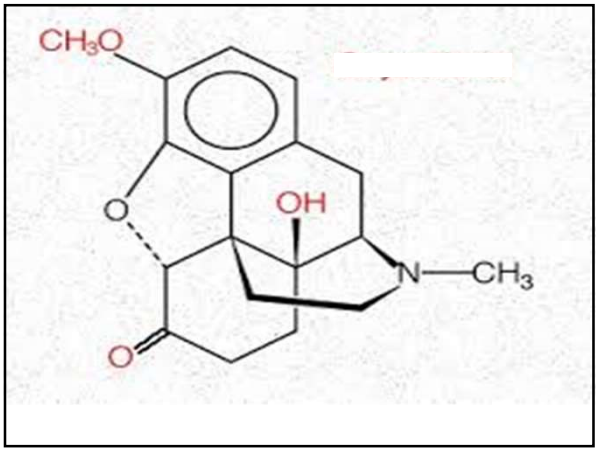
FINDINGS:

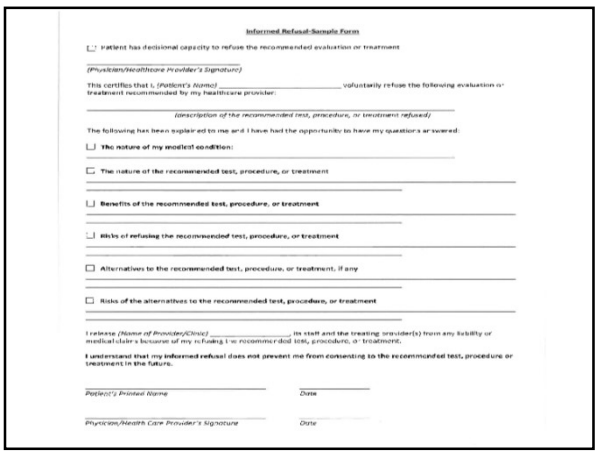
The lung bases are clear. No pathologic abdominal calcifications are identified.

The contrast-enhanced images reveal homogeneous enhancement of the liver and spleen, which are normal in size. No focal parenchymal abnormalities are identified. The gallbladder, pancreas, adrenal glands, and kidneys are within normal limits. There is no evidence of biliary ductal dilatation. The portal and hepatic veins are patent. No definite intraabdominal or retroperitoneal lymphadenopathy is identified. However, attention is directed to the multiple loops of dilated small bowel, consistent with a small bowel obstruction. The appendix is well imaged and normal. There is no evidence of free intraperitoneal air or free intraperitoneal fluid.

CT through the pelvis reveals the bladder to be well distended and smooth in contour. There is no evidence of free air or free fluid within the pelvis. No focal soft tissue mass lesions or lymphadenopathy identified.

The skeletal structures are grossly unremarkable.

**Informed Refusal-Sample Form**

☐ Patient has decisional capacity to refuse the recommended evaluation or treatment

*(Physician/Healthcare Provider's Signature)*

This certifies that I, *(Patient's Name)* _____ voluntarily refuse the following evaluation or treatment recommended by my healthcare provider:

_____
*(description of the recommended test, procedure, or treatment refused)*

The following has been explained to me and I have had the opportunity to have my questions answered:

☐ **The nature of my medical condition:**

☐ **The nature of the recommended test, procedure, or treatment**

☐ **Benefits of the recommended test, procedure, or treatment**

☐ **Risks of refusing the recommended test, procedure, or treatment**

☐ **Alternatives to the recommended test, procedure, or treatment, if any**

☐ **Risks of the alternatives to the recommended test, procedure, or treatment**

I release *(Name of Provider/Clinic)* _____, its staff and the treating provider(s) from any liability or medical claim because of my refusing the recommended test, procedure, or treatment.

**I understand that my informed refusal does not prevent me from consenting to the recommended test, procedure or treatment in the future.**

_____ _____
*Patient's Printed Name* *Date*

_____ _____
*Physician/Health Care Provider's Signature* *Date*

MOTIVATION

Autonomy
Mastery
Purpose

-*Drive: The Surprising Truth About What Motivates Us*
Daniel Pink

IRONY

# SUMMARY

1. EHR's and safety/risk
2. Sorry plus accountability- CRP-7 Pillars
3. Physician Burnout and Ways to combat- resiliency
4. Radiologist/Clinician communication
5. Systems- Redundacy
6. PAs and APNs
7. Opioids
8. Noncompliant and AMA patients
9. Where the cash is drives where the risk is- STROKE
10. Intrinsic Motivation- Autonomy, Mastery and Purpose