How to be a risk manager: Building your success

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MMIC Sr. Risk and Patient Safety Consultant
What you’ll learn today

one

How to use the risk management process to prevent patient injury and improve business performance.

two

How to develop interventions to reduce identified risk and enhance patient safety.

three

How to evaluate your risk management plan.
Lessons learned

• A 43-year-old woman saw her FP for an annual exam; he ordered a screening mammogram

• The radiologist noted a nodular density in the right breast and recommended an ultrasound for further evaluation

• The FP reviewed the report and ordered the ultrasound
Lessons learned

• The ultrasound showed a suspicious lesion and the radiologist recommended an ultrasound-guided biopsy

• The FP referred her to surgeon for the biopsy; the biopsy report indicated benign breast tissue and no evidence of malignancy

• An addendum to the biopsy report stated that the results were not consistent with the ultrasound and to consider sampling error
Lessons learned

• There was no evidence in her medical record that the FP reviewed the addendum report
• 2 ½ years later, she saw her FP for thickening in her right breast
• Her FP ordered a diagnostic mammogram
• The mammogram report indicated a 2 x 2cm mass highly suspicious for malignancy
• A biopsy revealed invasive ductal carcinoma
Lessons learned

• She underwent surgery and chemotherapy
• She filed a malpractice claim alleging a 3 year delay in diagnosing breast cancer and a lost chance of survival
• Experts were critical of the FP’s follow-up systems
• The claim was settled against FP and his clinic
Risk management and patient safety

Proactive approach
Prevent patient injuries
Prevent claims
Risk management process

- Risk identification
- Risk analysis
- Risk evaluation
- Risk intervention
Risk identification – the first step

- Identify potential adverse events
- Employ early interventions
- Build knowledge
- Identify trends
- Create strategies
Survey on Patient Safety

### Medical Office Survey on Patient Safety

**SURVEY INSTRUCTIONS**

Think about the way things are done in your medical office and provide your opinions on issues that affect the overall safety and quality of the care provided to patients in your office.

- In this survey, the term *provider* refers to physicians, physician assistants, and nurse practitioners who diagnose, treat patients, and prescribe medications. The term *staff* refers to all others who work in the office.
- If a question does not apply to you or you don’t know the answer, please check “Does Not Apply or Don’t Know.”
- If you work in more than one office or location for your practice, when answering this survey answer only about the office location where you received this survey—do not answer about the entire practice.
- If your medical office is in a building with other medical offices, answer only about the specific medical office where you work—do not answer about any other medical offices in the building.

**SECTION A: List of Patient Safety and Quality Issues**

The following items describe things that can happen in medical offices that affect patient safety and quality of care. In your best estimate, how often did the following things happen in your medical office OVER THE PAST 12 MONTHS?

<table>
<thead>
<tr>
<th>Access to Care</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Several times in the past 12 months</th>
<th>Once or twice in the past 12 months</th>
<th>Not in the past 12 months</th>
<th>Does Not Apply or Don’t Know</th>
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<tbody>
<tr>
<td>1. A patient was unable to get an appointment within 48 hours for an acute/serious problem</td>
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<td>Patient Identification</td>
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<td>2. The wrong chart/medical record was used for a patient</td>
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Assess your safety culture

1. Raise awareness
2. Assess current culture
3. Identify strengths & weaknesses
4. Examine trends in culture over time
Culture of safety values

- Commitment to safety at all levels
- Necessary resources allocated
- Safety is valued as a priority over production
- Communication is a defined process
- Openness about errors is the norm
- Learning from errors is the goal
Risk identification tools

Culture of safety survey
Patient experience survey
Risk identification tools

Culture of safety survey
Patient satisfaction survey
Patient complaints
Did you know?

70% - 80% of patients who seek legal advice after an adverse outcome are angry
Risk identification tools

Culture of safety survey
Patient satisfaction survey
Patient complaints
Incident reporting systems
Adverse outcomes and incidents

Missed fracture on X-ray
Missed or delayed diagnosis
Medication error
Fall in the office
Wrong procedure
Risk identification tools

Culture of safety survey
Patient satisfaction survey
Patient complaints
Incident reporting systems
Risk assessments
Risk identification tools

Culture of safety survey
Patient satisfaction survey
Patient complaints
Incident reporting systems
Risk assessments
Malpractice claim data
Diagnostic error risk report

MINIMIZE RISK
REDUCING DIAGNOSTIC ERROR IN YOUR CLINIC

In our analysis of Constellation outpatient medical professional liability claims asserted from 2010 to 2015, diagnostic error is the #3 most frequent allegation and #1 most costly.

#3 Occurrence | #1 Total incurred cost

Did you know? With almost half of the cases involving follow-up system failures, analyst reveals that accurate and timely diagnosis depends nearly as much on the health care team and system, as it does on the diagnostic process itself. Investing time and resources in boosting care team member communication skills, re-engineering diagnostic workflows, and implementing reliable HIT systems across care teams, improves efficiency and productivity and enhances the diagnostic process.

Top Major Allegations
Outpatient Claims
N=1,436 asserted 2010-2015

58%
Initial Diagnostic Assessment

Over half of all diagnostic errors in outpatient claims begin with issues that arise during the initial diagnostic assessment.

A family physician failed to consider and rule out breast cancer after a 27-year-old woman with a family history of breast cancer complained of bloody nipple discharge. Three years later, she was diagnosed with bilateral breast cancer. Cancer is the #1 missed diagnosis in outpatient claims.

When diagnosis of cancer is missed...
43% of cases involve the failure to establish a differential diagnosis during the initial diagnostic assessment.

26% involve a failure/delay in ordering a diagnostic test.

Top Missed Cancer Diagnoses
N=90

Breast 23%
Lung 13%
Skin 11%
Colorectal 7%
Prostate 4%
Uterine 4%
Other 30%

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Diagnosis error

N=2,867 asserted 2010-2015

484 cases (17%)

#3 occurrence across all settings
Diagnosis error

484 cases (17%)

$84.7 million (22%)

#3 occurrence across all settings

#2 total incurred cost
Diagnostic error cases

- Outpatient: 58%
- Emergency: 24%
- Inpatient: 18%

58% originate in outpatient settings
CRICO's 12-Step Diagnostic Process of Care Framework.
https://www.rmf.harvard.edu/Clinician-Resources/Article/2014/CBS-Diagnostic-Process-of-Care-Twelve
Follow-up system failures (FSF)

45% Outpatient cases with a major diagnosis-related allegation involved a follow-up system failure

Diagnosis-related Outpatient Cases

- FUSF 45%
- No FUSF 55%

MMIC N=285 PL outpatient cases asserted 2010-2015
Follow-up system failures (FSF)

Outpatient cases with a major diagnosis-related allegation involved a follow-up system failure.

Even when appropriate clinical steps are done to lead to the correct diagnosis, we still have diagnostic error.
Risk analysis – step two

Is the potential event low severity or high severity?
What is the probability this will happen?
Risk analysis tools

System analyses:
• Root cause analysis
• Failure mode and effect analysis
Root cause analysis
Retrospective analysis
Multi-disciplinary
Step-by-step investigation
Root causes identified
Prevention strategies
Root cause analysis

• What happened in this situation?

• What usually happens – norm?

• What should happen – policy?
Root cause analysis

- Why did it happen?
- How do we prevent it?
- How will we know we got better?
Failure mode and effect analysis (FMEA)

Prospective analysis
Focused review of specific process
Potential failures and impact of failures identified
Actions to reduce failure identified

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Risk intervention – step three

1. Eliminate the risk
Risk intervention – step three

1. Eliminate the risk
2. Prevent the risk
Risk intervention – step three

1. Eliminate the risk
2. Prevent the risk
3. Control the risk
Risk evaluation – step four

Data collection and analysis
Event and incident trends
Periodic policy and procedure review
Medical record audits
Risk, quality and patient safety program

- Commitment from leadership
- Designated accountable individuals
- Defined communication process
- Written comprehensive plan
Risk manager
Risk, quality and patient safety
Integration of risk, quality and patient safety

Data collection
Data sharing
Investigation of events
Performance improvement projects
Team education and training
Leadership reports
Risk management plan elements

Purpose and goals
Authority and accountability
Risk management functions
Risk management policies
Evaluation of the plan
Risk management plan elements

- All-hazards preparedness
- Media crisis relations
- Incident reporting and investigation process
- Cybersecurity
- Patient complaint-handling process
Risk management plan elements

Claim-handling process
Regulatory compliance
Peer review process
Privileging and credentialing
Adverse event disclosure process
Policy and procedure review

Annual review of all policies
Policy updates when services or care processes change
Documentation of review and revisions
Archives of outdated and terminated policies
Retention and destruction guidelines for archived policies
Risk management plan

- Reduced inefficiencies
- Improved productivity
- Higher reliability in care processes
- Reduction in patient injuries
- Prevention of unnecessary hospitalizations/readmissions
- Improved patient experience
- Better care coordination
- Fewer diagnostic, surgical, OB errors
- Fewer malpractice claims
Risk management

• Good for patients
• Good for care teams
• Good for business
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