Enterprise Risk Management: Implications for Healthcare Providers

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Objectives

- Define Enterprise Risk Management (ERM) and its application when managing adverse events
- Discuss the risk exposures for nurse anesthetists
- Examine the requirements for disclosure and mandated reporting in Pennsylvania and its implications to the Nurse anesthetist
Enterprise Risk Management

“Enterprise risk management refers to the ongoing business decision making process instituted and supported by an organization’s board, executive staff and medical staff leadership. The ERM program recognizes the synergistic effect of risks across the continuum of care, and it has as its goals the reduction of uncertainty and process variability, promotion of patient safety and maximization of the return on investment (ROI) through asset preservation, and the recognition of actionable risk opportunities.”

Adopted from the definition advanced by Roberta Carroll in “Enterprise Risk Management: What’s It All About?”
Goals of ERM Process

- Balance risk appetite and risk financing needs
- Comprehensive program structure to manage key risks
- Provides a framework to analyze risk and implement solutions throughout the organization
- Increases management’s ability to achieve strategic objectives
The primary objective of Enterprise Risk Management is to reduce the “unknowns” in organization risks

- “There are known knowns. These are things we know that we know.
- There are known unknowns. That is to say, there are things that we now know we don’t know.
- But there are also unknown unknowns. These are things we do not know we don’t know.” –

Donald Rumsfeld, Former U.S. Secretary of Defense
Implementing ERM: a continuous process
Enterprise Risk Management

- Healthcare Delivery (Patient Care)
  - Operational
    - Pt. Safety, Research, Education
  - Technology
  - Hazard
  - Financial
  - Human Capital
  - Strategic
  - Legal/Regulatory
Hazard

Event

1st order risks
Physical damage, personal injuries/deaths

2nd order risks
Consequential losses (production, profits)

3rd order risks
Indirect economic losses (market share, image, managing upset, personnel, lost investments...)

4th order risks
A consequence of the preceding risks

Cause

Visible, can be evaluated

Insurable

Poorly visible, difficult to evaluate

Not "insurable"
- First order risks (physical damage, injury, death)
  - Possibly due to misuse of device, malpractice claim
- 2nd order risks - Consequential losses (production, profits)
  - Did you need to stop this type of surgery for a period of time?
- 3rd order risks - Indirect economic losses (market share, image, managing upset, personnel, lost investments...)
  - If you stopped surgery, did MDs go elsewhere? Did you lose patients’ loyalty?
- 4th order risks - consequence of the preceding risks and unacceptable to society
  - How applicable is this in health care?
Liability Exposures

- Malpractice claims data reveals that Anesthesia claims rank in the top 10 for severity
- Exposure areas:
  - Medication errors
  - Wrong site procedures
  - Positioning
  - Monitoring – inadequate monitoring is the most expensive misadventure
  - Dental injuries
35-40% Of all malpractice claims are indefensible because of documentation problems.

Good documentation can prevent a malpractice claim or assist the defense by making an unavoidable outcome easier to explain!
Litigation and malpractice payments from 1991 to 2007 have been rising overall for PA’s and APN’s especially since 2000.
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Analysis

During the 17 year study period:

- Physicians - one payment for every 2.7 active physicians or 37% of physicians
- One for every 32.5 active PAs (3.1%)
- One for every 65.8 active and inactive APNs (1.5%)
- Physician mean payment 1.7 x higher than PAs and 0.9 x of APNs
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Note: verdict amounts are compensatory damages, but in a few instances may include punitive and delay damages as well as judicial offsets and adjustments. They do not reflect post-trial settlements or actions of an appellate court. They are not a report of actual payouts. Percentages may include rounding.
Disclosure

- **36 states** have implemented requirements for disclosure under law
  - laws differ & some are restrictive in what they actually protect
  - protection from admissibility varies by state

- Six states have enacted statutes that contain mandatory notification of adverse events to patients.
Pennsylvania

- First state in the nation to impose an explicit disclosure requirement on health care providers to inform patients of so-called “serious events”
- The statute does clarify that this written notification “shall not constitute an acknowledgement or admission of liability …”
The Medical Care Availability and Reduction of Error Act (MCARE)

Requirements: establish a Patient Safety Plan for the continuing purpose of improving the health and safety of its patients.

The goal of the ACT:

- to provide fair compensation and a prompt determination to a person who has sustained injury or death as a result of medical negligence by a health care provider
- while exerting every effort to reduce and eliminate medical errors through the identification of problems and implementing solutions that promote patient safety.
Defines a:

- **Serious Event**: an event, occurrence, or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in unanticipated injury requiring the delivery of additional health care services to the patient.
Patient Safety - Your Obligations

- Timely notification to the Patient Safety Officer or a call to the Patient Safety Hotline.
- Failure to report a medical error...
  - Licensure issues related to notifying the appropriate State Board in which you practice, i.e. State Board of Medicine, Nursing, Pharmacy etc.
- Failure to report a malpractice claim within 60 days of the filing of the complaint
  - Licensure issue - action against your license
How we respond to medical error and adverse outcomes
http://www.youtube.com/watch?v=UgxXPhb9zjI&feature
How we respond to errors affects important patient outcomes

- Errors and Adverse events are unavoidable
  - Healthcare is a fundamental human enterprise
  - High profile errors – publicity

**Woman Awarded $10.5 Million in Anesthesia Malpractice Case**

- Comply with regulatory requirements
  - Joint Commission
  - MCARE ACT 13 of 2002
Adverse Event Management Plan

Step 1. Stabilize Pt. & address immediate clinical needs
Step 2. Follow Institution’s Adverse Event Management Plan (24/7 support) – begin initial investigation
Step 3. Pt./Family Communication (Refer to Disclosure Policy)
Step 4. RCA – formal investigation & analysis of contributing factors associated with the complication

Frontline Staff - Inclusion in process; serious harm to a patient is the last thing that anyone wants to have happen

Organization - Serious adverse events pose a significant reputational risk to providers & institutions; respectful management of event is key

Disclosure Communication Can Be Difficult

- Communicating unexpected or disappointing outcomes
- Awkward - healthcare professionals are not trained to do them
- Important - demand for truthful and effective communication
- Necessary - resisting might result in malpractice litigation
- Require skill
- Explaining result of medical care, whether or not an error was involved
  - All outcomes should be “disclosed”
Disclosure of Unanticipated outcomes

- When; who; where
- Activate protocol based on severity of event
- What happened, Why it happened (if applicable), What’s being done to prevent it from happening again (if applicable)
- Team approach to prep and debrief (supporting providers)
- Documentation in medical record
Patient Preferences for Error Disclosure

- What patient’s want disclosed:
  - Explicit statement that an error has occurred
  - What happened including the implications for their continued health
  - Why it happened
  - How will reoccurrences be prevented
  - Importance of an “apology”

- “Considerations in the Disclosure of Serious Clinical Adverse Events”
  www.Healthlawyers.org/AdverseEvents
“An apology helps change the tone of discussion. It changes the discussion from, ‘I want to punish you; I want to get as much money from you as I can,’ to a conversation about what the patient and family need,”

“If there is fault- money will still exchange hands, but it’s not a lottery ticket.”

Doug Wojcieszak, founder of the Sorry Works! Coalition
Benefits of an apology/disclosure

- subtracts the insult from the injury,
- restores the injured person’s respect and dignity,
- decreases anger,
- helps prevent antagonistic behavior,
- promotes natural, open and direct dialogue,
- further reconciliation and
- assures the injured party that both the victim and the offender share the same moral values in a world with common ethical standards.

Information, candor, and an expression of accountability are what injured patients and their families look for.
Transparency has not been the catastrophe many predicted

- **Veterans Administration Hospital in Lexington, Ky.**
  - The program has attained significant rewards.
  - Lexington's average malpractice award decreased from $98,150 to $15,622, with less than 10% of malpractice claims were filed in court, and most of these were dismissed before trial.

- **The University of Michigan Health System adopted a similar program**
  - seen a reduction in attorneys fees resulting in its legal budget decreasing from $3 million to $1 million,
  - the number of claims filed has decreased each year and
  - its claims processing period was reduced by more than 50%.
Barriers to disclosure

- Legal Barriers:
  - Concerns over discoverability
    - Overcoming or negating a perception of cover-up is a much more difficult task than overcoming the characterization that an apology is an admission of fault.
  - Disclosure should be factual and broad

- Most patients don’t want or need the details of process improvement
  - Desire to know how the healthcare organization responded to the event by making changes so the same event won’t happen again
    - Possible approach:
      - “In our investigation we learned that an area in our pharmacy process could be improved to prevent this type of error and some of those changes have been instituted already”
Barriers to disclosure

- Most often patients become plaintiffs because they feel there is information the clinician or the hospital has denied them, especially if the review of their medical record or a deposition reveals information that has not been disclosed.
The Cycle of Care

Patient’s Experience

Patient’s Access to Information

Patient Understands Outcome

Patient Expectations

Interrupting this cycle increases the risk that patients will turn to lawyers
Structured approach- FEARED

- Get all the **Facts**
- Express **Empathy** and **Educate**
- Searches for sources of **Anger**
- Have the patient **Relate** back to you her understanding of your explanation
- Evaluate the **Extended** family response
- **Document** the conversation

Michael Woods, M.D. and Fay Rozovsky, J.D., M.P.H.

*What Do I say? Communicating Intended or Unanticipated Outcomes in Obstetrics, 2003*
Responding to Patient’s Emotions

- Anger is a common response to hearing of an error
- Empathetic communication is important
- Try to identify what specifically about the error the patient is most upset about
- Calm demeanor - can prevent anger from escalating
- Defensive comments can heighten patient frustration and anger
Remediation Plan

- Is there an imminent danger to other patients?
- Formal Investigation - Root Cause Analysis
- Tracking & Trending via Occurrence/Event Reports
- Peer Review (pre-op & intra-op factors)
- Lessons Learned
- Possible systems re-design or other corrective action planning (consider formal checklists, approved clinical guidelines/protocols)
Adverse Events

- **Shared decision making (patient, surgeon, anesthesia professional)**

- **Who is “at risk?”** patients, providers, institutions, industry, insurers

- **Informed consent (timing and by whom?)**
  - Most likely the surgeon; giving the patient time to consider risks, benefits and alternatives - Comply with Institution’s policy

- **How is anesthetic and surgical management influenced?**
  - Track/Trend adverse events
  - Implement best practices (checklists/guidelines/protocols)
THANK YOU!

Questions???