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New risks in the enterprise: Managing the risks of ACOs

By Barbara Youngberg, JD, BSN, MSW, FASHRM

Part of what keeps risk managers excited about their jobs is the variety in the work they do. In any given week, they can find themselves involved in something new – investigating a patient injury, preparing a statement in advance of a liability claim, educating staff on ways to maintain safety for themselves or their patients, assisting the CFO in designing the appropriate risk transfer or financing strategy for the organization, or gathering information to enforce compliance of a new law or regulation.

With the passage of the sweeping healthcare regulation frequently referred to as Obamacare, risk managers may feel that the rules they previously understood to guide their jobs have changed. In reality, much will remain the same, although the law, when fully implemented, will transform many aspects of healthcare delivery.

The goals of Accountable Care Organizations

Many of the skills risk managers already possess, and some that we continue to develop, will be the same skills necessary to manage the risks inherent in providing care through the new structure envisioned by the Affordable Care Act – the Accountable Care Organization (ACO). Under the ACO model, the primary goal is to enhance the coordination of care to ensure patients, especially the chronically ill, get the right care at the right time while avoiding unnecessary duplication of services.

According to Donald Berwick, MD, MPP, FRCP, President Emeritus and Senior Fellow, Institute for Healthcare Improvement (former Administrator, Centers for Medicare & Medicaid Services), the triple aim of ACOs is to provide :

- ✓ *Better care for individuals*
- ✓ *Better health for populations*
- ✓ *Lower per capita costs of care without any harm whatsoever to patients*

Continued on page 2

Principles of enterprise risk management (ERM) are actually well-aligned with the ACO model. When an ACO succeeds in delivering high-quality care and in spending healthcare dollars more wisely, it will share the savings it achieves for the Medicare program with its providers. It is also likely that when an ACO succeeds in achieving those goals, risks will be reduced and safety will be enhanced. Although critics of ACOs feel they are nothing more than health maintenance organizations, others believe that focus on care coordination and focus on quality (with the need to report quality metrics as a basis for payment and triggering financial rewards) are more strongly embedded into the type of care under an ACO, and thus likely to be greater drivers of how care is provided than cost savings alone.

When the rule governing ACOs initially passed, many speculated that the cost of setting up the organization would be significant and the ongoing operational challenges would make it impossible for all but the largest systems to participate in this new model. With a softening of the regulations and greater clarification of some of the features that seemed to contradict well-established law regarding physician referral, financial incentives, and billing, ACOs are rapidly emerging as the preferred model of care for Medicare patients. If they are able to deliver on the goals established, it is likely this model will also be effective in treating non-Medicare patients, as well.

Risks of ACOs

There are three general classes of risks most often associated with ACOs: legal risks, financial risks, and operational risks.

Legal risk management

Primary legal risks relate to the creation of an ACO in the manner that assures it will remain in compliance with all laws, rules, and safe harbor regulations, including Stark laws, antitrust laws, and anti-kickback laws. These laws were all initially enacted to assure appropriate incentives were applied to the business practices of medicine, and specifically that treatment decisions were predicated on what was best for patients rather than what would allow the provider to earn the greatest amount of money. These legal risks are typically handled by external counsel who work with the general counsel of a healthcare organization.

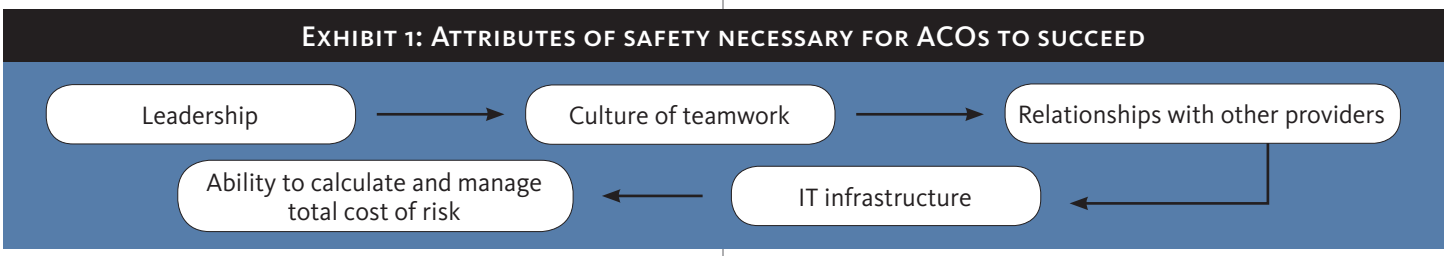
In addition, state-based laws limiting the corporate practice of medicine and establishing eligibility for tax exemption have been important in assuring that physicians have the responsibility and autonomy for caring for their patients and that provider organizations who provide charity care to patients who cannot afford medical care (and offer other services to the communities in which they are located) are incentivized to continue these practices through the offering of tax incentives.

Financial risk management

The second area of risk is one that has received a great deal of attention when contemplating ACOs. The ability to assume financial risk for the care provided was thought by some to be an impediment to participating in or establishing an ACO. In the initial rule, there was an expectation that, at the onset of operation, providers would not only receive cash incentives for providing high-quality and cost-effective care, but that they would be required to return money to the Medicare program if they failed to meet the quality and cost targets. The potential of having to pay back Medicare proved very unattractive to all but the most sophisticated providers. Furthermore, the infrastructure required to track and report quality and manage costs across the continuum also made many feel that the up-front investment in infrastructure would far exceed any potential for financial return.

With the release of the final rule, many of these concerns were addressed and providers were able to select an ACO model which would allow for a more gradual approach to accepting financial risk. This type of risk is generally beyond the scope of the healthcare risk manager, so at least in the initial phase of ACO creation, the chief financial officer would likely be the point person for these discussions. Once an ACO is operational, the enterprise risk manager might be instrumental in helping providers understand the total cost of risk, including all malpractice-related expenses, in order to develop an annual budget that factors in all costs associated with the ACO providing care, as well as financial returns anticipated in light of meeting quality and financial targets.

Exhibit 1: Attributes of safety necessary for ACOs to succeed



Operational risk management

The operational risks associated with an ACO are likely familiar to risk managers whose responsibilities extend beyond the acute care setting. Exhibit 1 identifies some of the skills and attributes necessary to maintain quality and safety in ACOs.

Since ACOs will generally operate outside the four walls of the hospital and manage patients across many different healthcare encounters, risk managers must pay close attention to the common risks associated with providing care in any setting. The risks associated with ineffective communication can be

problematic; effective communication is necessary when a patient is receiving acute care by a team of providers, as well as when that patient is handed off to a team of healthcare professionals who will be assisting with care and support (e.g. rehabilitative care or primary and preventive care) following the acute stage of illness.

In an ACO, it is important to proactively address any potential impediments in communication caused by hierarchy as, in this setting, it is possible that advanced practice nurses will be managing patient populations. Ancillary providers (physical therapists, pharmacists, social workers, and others) will also be essential to managing a patient across the continuum of care. Given that care will be provided across multiple facilities and a longer period of time, electronic health records will be necessary. The risk manager will need to ascertain that all information security and privacy concerns have been addressed. Clearly the need to communicate across all sites of care and between all providers will be essential as well-coordinated care is necessary to achieve optimal outcomes.

If a risk manager is already aware of current communication and hand-off issues causing quality of care problems in the organization, she or he may wish to provide TeamSTEPPS®* training to ACO providers, or design specific tools/checklists which can be used to create a standardized protocol for the transfer of all relevant information. This will help ensure that patient hand-offs do not contribute to medical error or serve to degrade the continuity of care.

The importance of teamwork

Care can also be compromised when there is an absence of teamwork. In the ACO setting, the team of providers is likely to be larger than those providing inpatient-only care. Using simulations to identify issues that can impede teamwork skills is a great proactive strategy risk managers can employ to prepare providers for this change in care delivery.

Conclusion

Leadership remains essential to safe care, and risk managers can assume leadership roles by carefully examining the aggregate root causes of error in the current organization and determining the impact they might have on the organization's new ACO. Valuable communication tools and training strategies are available and risk managers can begin educating providers and staff on the importance of implementation – creating a culture of teamwork that supports effective communication, safe hand-offs, and optimal patient outcomes. Only then will the ACO achieve its risk management goals and share in the financial reward envisioned by the ACO model.

Barbara Youngberg, JD, BSN, MSW, FASHRM, is Senior Healthcare Risk Management Specialist for Sedgwick.

* TeamSTEPPS is an evidence-based teamwork system to improve communication and teamwork skills among healthcare professionals. See http://teamstepps.ahrq.gov.

Resources to support medication safety

The challenge to remain ahead of every potential medication safety issue can be a daunting task, not only for clinicians, but also for risk management and patient safety professionals. Reviewing information about medication errors caused by system failures such as look-alike/sound-alike medications, packaging similarities, drug recalls and shortages, and newly published research on medication risks and side effects is an important step in understanding and managing the risks. In the past, it was necessary to reference a wide variety of publications and websites to stay informed about medication safety news and alerts. Now it is possible to visit just a few sites, thanks to the collaboration of professional societies, organizations, and government agencies that focus on medication safety and error prevention.

The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) is an independent body of 27 national organizations that includes the American Pharmacists Association, The Joint Commission, American Medical Association, American Society for Healthcare Risk Management (ASHRM), and others. The goal of NCC MERP is "to maximize the safe use of medications and to increase awareness of medication errors through open communication, increased reporting, and promotion of medication error prevention strategies." The NCC MERP Index classifies errors according to outcome severity in order to assist healthcare organizations with tracking medication errors in a consistent and systematic manner. The National Alert Network (NAN) is a coalition of members of NCC MERP, publishing complimentary newsletters and alerts. The Institute for Safe Medication Practices (ISMP) and the American Society of Health-System Pharmacists (ASHP) publish incident-driven alerts from the National Medication Errors Reporting Program, operated by ISMP. See the links on page 4 to learn more about each and to subscribe to these alerts and newsletters.

The U.S. Food and Drug Administration (FDA) coordinates medication safety activities through the Division of Medication Error Prevention and Analysis (DMEPA), a department within the Center for Drug Evaluation and Research. DMEPA staff review medication error reports sent to MedWatch, another FDA medication safety program, to evaluate causality, analyze data, and provide solutions to reduce the risk of medication errors. The DMEPA prospectively examines proprietary names, labeling, packaging, and product design prior to drug approval to help prevent medication errors. The DMEPA works closely with patient safety organizations such as ISMP, standard-setting organizations such as the United States Pharmacopeia, and foreign regulators to address broader product safety issues. Stay informed through the MedWatch website and safety alerts, noted on page 4.

Sedgwick's risk management and patient safety staff recommends the following resources to help you stay current in your medication safety program:

- ✓ Access more information about NCC MERP: http://www.nccmerp.org/
- ✓ Access NAN and sign up for alerts and newsletters: http://www.nccmerp.org/nationalAlert.html
- ✓ ISMP publishes several medication safety newsletters that can be accessed at: http://www.ismp.org/newsletters/default.asp. Tools addressing specific areas of medication safety concerns are downloadable at no charge at: https://www.ismp.org/tools/default.asp
- ✓ Access the ASHP website: http://www.ashp.org/
- ✓ Access the MedWatch website: http://www.fda.gov/Safety/MedWatch/default.htm
- ✓ Subscribe to MedWatch safety alerts: https://public.govdelivery.com/accounts/USFDA/subscriber/new?pop=t&topic_id=USFDA_46

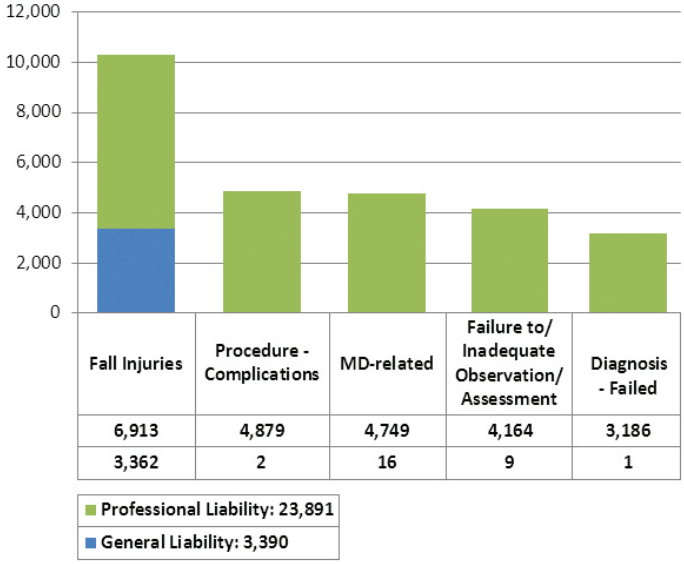
Sedgwick claim study reveals injuries from falls as a top claim cause and loss leader

By Ann Gaffey, RN, MSN, CPHRM, DFASHRM

Injury from patient and visitor falls continues to be a source of professional and general liability claim activity that challenges and frustrates risk management and patient safety professionals across the continuum. While not always the most significant claim on the organization's books, there are still many of these events that result in debilitating fractures, neurologic damage, and death.

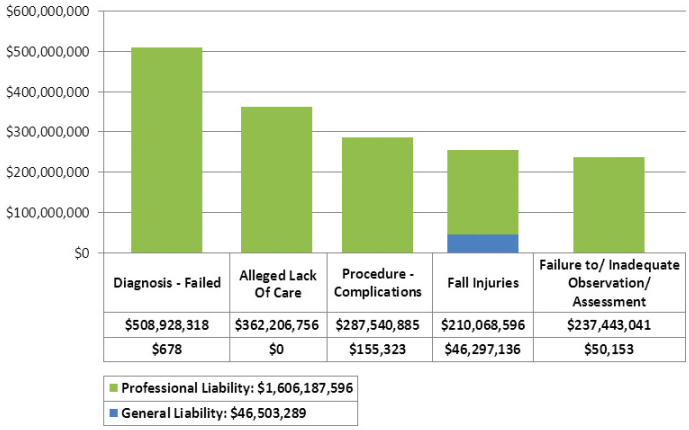
An analysis of protected data in the Sedgwick study revealed some big numbers that stood out. Focusing on healthcare clients, over 10,000 or almost 17% of the 62,000+ claims and suits analyzed for this study were attributed to injuries from falls – the number one injury cause, as noted below:

Sedgwick claim study - Top five causes by file type



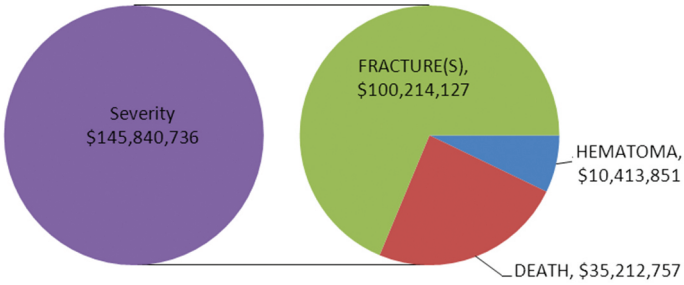
In addition, even though fall injuries are not always considered high-severity cases, they were among the top five based on indemnity costs and allocated loss adjustment expenses (ALAE) paid, as shown:

Sedgwick claim study - Indemnity and ALAE paid for top five causes by file type



The combined indemnity and ALAE payments associated with the most frequent results from falls – fractures, hematomas, and death – came in at $145.8 million. Looking at all fall claims and lawsuits in the Sedgwick claim study, that number exceeded $254 million.

Sedgwick claim study - Indemnity and ALAE paid for top three injuries correlating to fall injuries



When considering the financial loss an organization can experience from Medicare non-payment of hospital-acquired conditions (HACs) associated with falls (fracture, dislocation, intracranial injury, and more), this patient safety issue must remain top-of-mind. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the HACs was not present on admission. Specifically, the case would be paid as though the secondary diagnosis were not present.[1] Examination of data from the Centers for Medicare & Medicaid Services from an April 2012

analysis by the Research Triangle Institute (RTI) showed the estimated cost to Medicare per episode for a hospital fall with a fracture at $7,198.[2] Loosely associating that to the Sedgwick data, this adds a potential cumulative loss due to Medicare non-payment to facilities of $34 million.

These significant findings are enough to move any risk management and patient safety professional into high gear to evaluate their existing fall prevention programs. The need to take a closer look at which risk reduction initiatives are working and which are not is evident. Medicare's position of not paying for an injury that could reasonably have been prevented through the application of evidence-based guidelines should motivate risk management and patient safety professionals to benchmark facility practices against those supported by strong clinical evidence.

One should not assume, however, that all falls occur in a specific segment of the population, such as the elderly. Often overlooked patient demographics include obstetric and postpartum patients, as well as infants who may experience falls when new parents fall asleep while holding them in their arms. Equally important are the acute rehabilitation patient who believes they have progressed farther in their rehabilitation than they have and then fall while attempting to walk on their own, or the outpatient who has a radiology test and falls while getting off the x-ray table. To address risks across these widespread populations, there are extensive resources available for assessing and benchmarking a facility's existing fall prevention tools and programs (see resources list).

Not to be forgotten is the important analysis to be done after a patient or visitor falls. Risk identification efforts should include an event reporting system that collects detailed information specific to each fall, such as time of day, location, activity at time of fall, medication changes, environmental factors, etc. In partnership with quality and patient safety professionals, analyzing rate-based fall data on a regular basis for trends and risk control opportunities will round out a fall prevention program. If patient falls are a significant problem in the facility, consider a weekly dedicated "fall team" meeting to analyze the details of every fall. This multidisciplinary forum can include therapy and pharmacy professionals, housekeeping staff, nutrition services, social services, physicians, and others as needed to improve facility performance in mitigating these high-risk incidents.

As highlighted in the Sedgwick claim study findings, injuries from falls in all types of patient care facilities can significantly impact the bottom line when frequency or severity is an identified problem. Using the resources noted here, along with facility-specific fall and claim data, opportunities exist to improve patient safety and ensure robust fall prevention programs are in place.

Interested in learning more about the Sedgwick claim study and ways to reduce the most common risks? Join Ann Gaffey and Jayme Vaccaro on Monday, October 28, 2013 at the ASHRM Annual Conference & Exhibition in Austin, Texas when they present "Driving Down Claims: Tackling the Top Ten."

Ann Gaffey, RN, MSN, CPHRM, DFASHRM is SVP, Healthcare Risk Management and Patient Safety for Sedgwick.

References:

[1] Department of Health and Human Services and Centers for Medicare & Medicaid Services. Hospital-Acquired Conditions (HAC) in Acute Inpatient Prospective Payment System (IPPS) Hospitals Fact Sheet, October 2012. Found at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/downloads/hacfactsheet.pdf.

[2] Centers for Medicare & Medicaid Services Analysis Report: Estimating the Incremental Costs of Hospital-Acquired Conditions (HACs), April 2012. Found at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/HospitalAcqCond.

HELPFUL RESOURCES

1. AHRQ Falls Management Program for Nursing Facilities: Appendix B2: Tracking Record for Improving Patient Safety (TRIPS): The Falls Management Program Manual. February 2010. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/systems/long-term-care/resources/injuries/fallspx/fallspxmanapb2.html.
2. AHRQ: The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities, October 2005. Found at: http://www.ahrq.gov/research/ltc/fallspx/fallspxmanual.htm. Specific to Fall Risk Assessment is a Falls Assessment Cue Sheet (Appendix B, #5) to use as an adjunct to initial and ongoing fall risk assessments.
3. American Geriatric Society/British Geriatric Society Clinical Practice Guideline: Prevention of Falls in Older Persons (2010). Found at: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2010/.
4. Evidence-based Guidelines for Selected and Previously Considered Hospital-Acquired Conditions, May 1, 2013. Found at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/Evidence-Based-Guidelines.pdf.
5. Falls in Radiology: Establishing a Unit-Specific Prevention Program. Pennsylvania Patient Safety Authority Safety Advisory. 2011 Mar: 8(1): 12-17. Found at: http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2011/mar8(1)/Documents/mar;8(1).pdf.
6. Heafner, L., Suda, D., Casalenuovo, N., Leach, L., Erickson, V., And Gawlinski, A. (2013). Development of a Tool to Assess Risk for Falls in Women in Obstetric Hospital Units. Nursing for Women's Health, 17(2), 98-107. Abstract found at: http://www.ncbi.nlm.nih.gov/pubmed/23594322.
7. Institute for Healthcare Improvement's "Reducing Harm from Falls" Initiative, April 2011. Injurious Fall Data Collection Tool. Found at: http://www.ihi.org/knowledge/Pages/Tools/InjuriousFallDataCollectionTool.aspx.
8. Quigley, P., Neily J., Watson, M., Wright M., and Strobel, K. (2007). Measuring Fall Program Outcomes. The Online Journal of Issues in Nursing, 2(10). Found at: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No2May07/ArticlePreviousTopic/MeasuringFallProgramOutcomes.html#Fig2.

TechnologyBytes

BY ANN GAFFEY RN, MSN, CPHRM, DFASHRM

Maximizing electronic health record functions to improve medication reconciliation

The implementation of electronic health records (EHRs) has added efficiency to many processes and their use contributes to improved accuracy of important patient data. Case in point: the process to reconcile medications.

Medication reconciliation (MR), as defined by the American Medical Association,

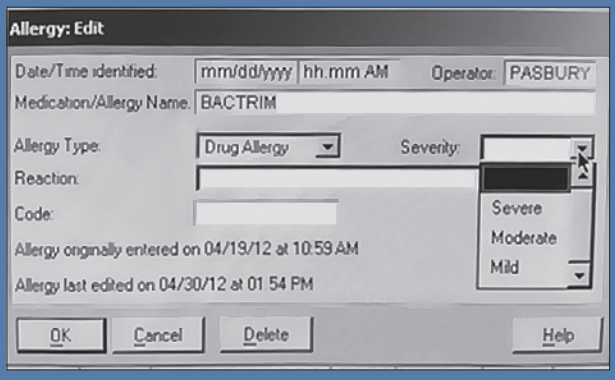
...is making sense of a patient's medications and resolving conflicts between different sources of information to minimize harm and maximize therapeutic effects. It is an ongoing, dynamic, episodic, and team-based process that should be led by and is the responsibility of the patient's attending/personal physician in collaboration with other health care professionals (AMA, 2007).[1]

When assessing the reconciliation process in hospitals and physician practices using paper medical records, the information collected can vary widely, is frequently inaccurate or incomplete, and at times illegible. Shifting from that inefficient manual data collection process to the more consistent and accurate EHR process when maximizing MR functions, improved patient safety is sure to follow.

When seeking best practices to ensure safe patient care related to MR, physicians and nurses in hospitals and office practice settings should make sure specific tasks are performed to gather a complete and accurate medication list from the patient. These activities will help to recognize gaps or inconsistencies in EHR systems that impede MR. A significant amount of literature has been published that confirms and addresses the safety issues involved with poor or absent MR in the outpatient setting. The scope of medication-related errors is as extensive or more extensive in the outpatient setting than during hospitalization, with one study estimating the rate of adverse drug events (ADE) in the ambulatory setting to be 27 per 100 patients. When breaking the events down further, the more vulnerable population for ADEs is individuals aged 65 or older, in part due to their higher use of multiple medications.[2]

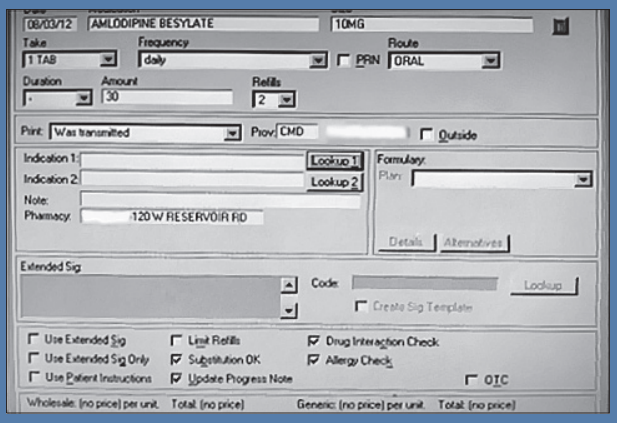
The EHR provides a much more robust opportunity for complete MR than a paper medical record. The process "forces" standardization and ensures legibility in the electronic format. In addition, fields are available to document key information, including drug name, dose, route, frequency, indication for use, start and stop dates, ordering provider, allergies and the associated allergic reaction and severity. Rarely does one see all these data elements when reviewing MR documents in a paper medical record.

In evaluating MR modules in office-based EHR products, frequent gaps were noted when assessing the full use of the MR function. Several reasons were identified for the incomplete use of the reconciliation function, including incomplete training of end-users, failure to re-train or educate about product upgrades, lack of end-user knowledge of the EHR product itself, and concerns about the amount of time to complete every data field available. Unfortunately, when the MR function is not used to its full capability, critical information can be missing. For example, the first screen shot below demonstrates that while the EHR has easy-to-use functions to document both reaction to a drug and the severity of the reaction, neither field was completed – a frequently seen gap. When this information is not available, physicians have to conduct further questioning of patients about the reaction before prescribing a medication. In addition, this means incomplete information is available to others that also have access to the patient's EHR in a healthcare system. This is inefficient, is not patient-centered, and negates the purpose of having these data fields available.

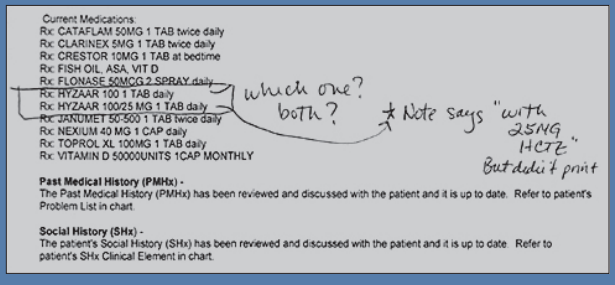


Another commonly seen problem is the omission of complete information about the indication for the drug, as noted in the next screen shot. An indication for taking a medication is important information for a patient when managing their medications at home. For example, if they don't know a particular drug is for hypertension and another is an anticoagulant, they may make poor decisions about which

drug to refill if money is an issue when making choices about refills. Because this data generally can be printed out on a visit summary, providers should make every effort to provide the most complete information possible to the patient, ensuring there are no duplicates on the medication list, and that all directions for taking the medications are also provided in writing. With current "meaningful use" requirements around providing printed visit summaries to patients, the extra step of reviewing what interfaces from the EHR and prints to the visit summary is an important final step to provide the patient the most accurate and complete information about their visit.



The visit summary printed from an EHR has information for patients to reference after their visit – diagnosis, diagnostic tests ordered, medications, etc. When the EHR functions are not used properly, the resulting information given to the patient can be confusing or incorrect. Providers should be trained on how to use the full functionality of each data field as viewed above when prescribing, renewing, changing dosage, or discontinuing a medication. This should include how to accurately record indications, document instructions regarding how to take the medication, and other important information. In the picture below, one medication appears twice in the list, because the provider did not appropriately "discontinue" a medication in the EHR. Even though the dosage was changed, that change did not overwrite the previous dose, but rather added it to the list. A clear written explanation is not given as to whether or not two different doses of the same medication should be given to get to one larger dose.



EHRs are improving legibility of medication orders and providing opportunities to improve the MR process. However, when this electronic documentation tool is not used as intended, medication errors may occur. Risk management and patient safety professionals should ensure they have an active and ongoing presence on their organization's information technology committee. Their expertise should be offered when decisions are being made about EHR product selection and implementation plans and which modules or data fields will be activated and to what level, as well as initial and ongoing end-user training, and methods to identify potential safety events related to EHR use.

Ann Gaffey, RN, MSN, CPHRM, DFASHRM, is SVP, Healthcare Risk Management and Patient Safety for Sedgwick.

References:

[1]American Medical Association. (2007). Making Strides in Safety Program: The physician's role in medication reconciliation: Issues, strategies and safety principles.

[2]Gandhi T., et al. (2003). Adverse drug events in ambulatory care. New England Journal of Medicine, 348(16), 1556-1564.

There are numerous resources available to support medication reconciliation in the ambulatory setting, including but not limited to the following:

1. The Institute for Safe Medication Practices, found at: www.ismp.org
2. Massachusetts Coalition for the Prevention of Medical Errors: Reducing Medication Errors in Ambulatory Settings – Medication List, found at: www.macoalition.org/reducing_medication_errors.shtml
3. National Transitions of Care Coalition – Consumer Resources, found at: www.ntocc.org/WhoWeServe/Consumers.aspx
4. AMA Medication Reconciliation Monograph: The physician's role in medication reconciliation: Issues, strategies and safety principles (2007)
5. Institute for Healthcare Improvement: Reconcile Medications in Outpatient Settings, found at: http://www.ihi.org/knowledge/Pages/Changes/ReconcileMedicationsinOutpatientSettings.aspx
6. Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation, found at: http://www.ahrq.gov/qual/match/
7. AHRQ Publication: 20 Tips to Help Prevent Medical Errors – Patient Fact Sheet, found at: http://www.ahrq.gov/legacy/consumer/20tips.htm

Assessing patient safety risks in office practices: An opportunity for learning and improvement

By Kathleen Shostek, RN, ARM, BBA, FASHRM, CPHRM

As hospitals and health systems increasingly seek to purchase physician practices as a strategy to increase competitive advantage, stabilize bottom lines, and improve market share, risk managers are frequently asked to assess the risks of the practices either before or immediately after acquisition. With family practice and internal medicine specialties in highest demand[1], having a plan to assess the activities that generate the most risk in these types of practices will serve risk managers well.

The American Medical Association's report on ambulatory patient safety identified diagnostic errors, laboratory errors, and communication errors among the top categories of errors that contribute to patient harm.[2] In a recent review of malpractice claims, it was noted that diagnosis-related errors were the most common (>35% of total settlement dollars), most costly (average payment/claim >$385,000), and most likely errors to result in significant harm.[3] In a study that focused on the primary care setting, diagnostic errors were found to be related to process breakdowns during the clinical encounter, communication breakdowns associated with referrals, issues involving patient compliance, follow up and tracking of diagnostic information, and performance and interpretation of diagnostic tests.[4]

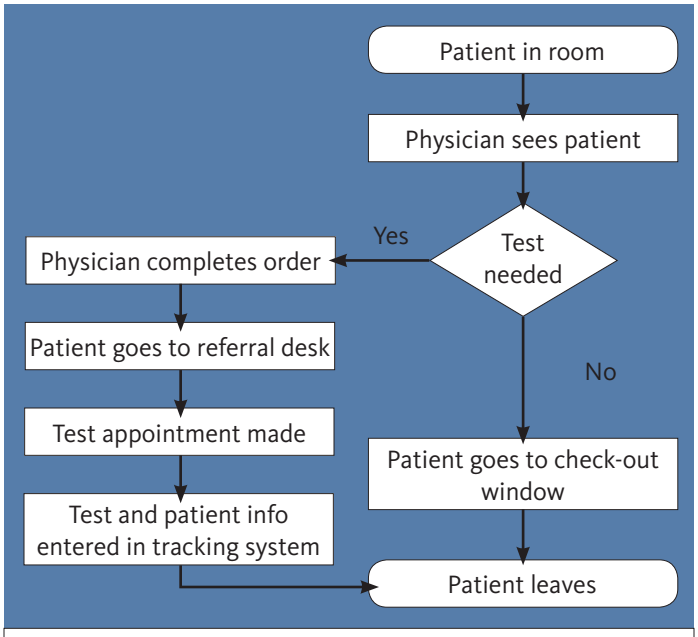
Reducing diagnostic errors

Assessing patient safety risks in office practices should begin with an evaluation of methods used in the practice to prevent or reduce diagnostic errors. A critical process in the office setting related to accurate diagnosis is test results management. Working with the provider, office nurse, and/or office manager, the risk manager can help map out the diagnostic testing process to identify best practices and correct vulnerabilities.[5] This can be done using a focused rapid risk assessment in lieu of a comprehensive practice assessment, which is ideal but may be impractical due to time and resource limitations.

Engaging the office provider and staff in learning how to rapidly assess the areas in their practice associated with the greatest risk can reap the greatest rewards. Benefits to this "rapid" approach are that it gives the risk manager an opportunity to teach staff about the highest patient safety risks (such as unreliable test tracking and the importance of recognizing and reacting to critical values) and recommend ways to mitigate risks associated with them. It also allows providers and staff to "own" the solutions and improvements, thereby opening the door to additional rapid risk assessments in other areas of the practice. Celebrating and then making the most of early successes will go a long way in spreading patient safety and risk management concepts into the office practice setting.

Rapid risk assessment: Results management

An assessment of diagnostic test management should begin with the order for a test (laboratory or imaging test, for example) and map out the clinical workflow from that order through reception of the test results to identify the steps in the process, any technologies involved, and the people responsible for them. An adaptation of the tracer methodology can be used to quickly document the workflow and create a flow chart. Tracer methodology is used to trace a specific care process by following the path of a system and observing it as it is carried out in order to clearly understand the process.[6] A flow chart graphically represents the flow of a process.[7] Below is a simple flow chart example.



(Patient leaves after staff confirms where and how test results will be communicated.) *Flow chart adapted from Quality Improvement, Patient Safety & Efficiency in Outpatient Practice; 2011. Used with permission from the author, Margaret Curtin, Director of Education, Michigan Professional Insurance Exchange (MPIE).*

Once the process from test order to test result is clearly understood, specific questions can be asked to identify potential (or known) problems or breakdowns in the process leading to errors or delays. Assessing the process through questioning, learning about best practices, identifying a process for recognizing and communicating critical values, and identifying possible other safety improvements can occur simultaneously. This approach allows the risk manager to help the practice gather important information about test management while teaching about best practices and recommending improved processes. It also helps providers and staff understand the value of the risk assessment as a means of improving safety and reducing errors.

Examples of assessment questions, best practice lessons, and safety improvements are noted in the table below.

Rapid risk assessment: Results management		
Assessment question	Best practice lesson	Safety improvement
Is the test ordering-to-result process a standard one, or are there variations?	Standardization reduces errors. Forms, logs, and checklists are methods used by some practices to standardize processes.	Standardization of the process for common laboratory and radiology tests reduces likelihood of missed steps and errors.[8]
Do all providers and staff follow the same process?	Create expectation for use of a standard process.	Compliance with standard processes reduces error.
Has accountability been assigned for reconciling orders with results received?	Assigning responsibility improves likelihood that critical functions will be carried out.	Nurse completes daily test log to track outgoing and incoming tests; acts on delayed/lost reports.
Is there a consistent process for provider review and documentation of all test results?	Consistent processes for provider review and documentation reduces possibility that test results will be missed or overlooked.	Test results are consistently reviewed with documentation by providers prior to filing in the record.
Is there a means to highlight test results/alert provider to results that require urgent attention? (Critical values)	A system (manual or automated) that identifies critical test results facilitates timely intervention.	Electronic systems with automated results management improve test result management.[9] In the absence of a technology-based system, a rigorous manual system is recommended.
Is there a plan for covering/on call providers to review test results?	A robust plan for providers who provide on call or other coverage prevents delays or failures to review test results.	During provider absences from the office, review and follow up of test results is carried out by covering providers.
Are patients notified of all test results?[10]	Patient satisfaction is improved with communication of test results and with subsequent treatment related to results.[11]	Patient satisfaction with their experience of care is a key risk management and patient safety indicator.
Are patients instructed to call the office if they have not received test results in a specified time frame?	Involving patients in their care and safety supports healthcare engagement and compliance.	Patients receive a written summary of their office encounter that includes follow up instructions for test results.
Are test tracking and follow-up processes regularly monitored?	Quality monitoring (auditing) allows identification of process failures and noncompliance.	Test result management practices from order to result through patient notification and follow-up are audited periodically.[12] Variances are corrected.

Offering suggested best practices and tools to proactively implement can help gain trust and credibility in risk management as a "go to" department for patient safety solutions; many sources are included in this article's reference list. Following a risk assessment, risk managers should continue to serve as a resource to office practices, providing support for implementation of selected strategies. Building a relationship with providers and office staff can foster assessment of other high-risk processes in the practice, provide an opportunity for ongoing education, and enhance the implementation of reliable patient safety and risk management solutions beyond test result management.

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Covenant Health celebrates TeamSTEPPS® successes

Covenant Health, Lubbock, TX is a year into their journey to improve communication and the culture of safety through TeamSTEPPS following their two-day Champion training by Sedgwick master trainers. "We targeted our interventional areas first (OR, PACU, Cath Lab, Endoscopy, and Interventional Radiology)," said Brenda Kinning, Director of Risk Management and Patient Safety Officer, "then spread TeamSTEPPS to Obstetrics and the Emergency Department." When hospital staff outside of these areas heard about the positive effects of better teamwork and communication on patient safety and the work environment, they asked for TeamSTEPPS training in their units. Now, many others are attending the training, including staff from the ICUs and Med-Surg units, as well as other areas of the hospital.

Brenda notes, "Although TeamSTEPPS training is not mandatory for our medical staff, the number of physicians participating in the training sessions is increasing. We have a growing number of staff committed to improving our culture of safety. In order to support the continued spread and implementation of the tools and strategies, we capture success stories and share them. The payoffs include both a return-on-investment in our safe culture initiative and conversion of skeptics to the TeamSTEPPS side!"

TeamSTEPPS has helped the staff shift to a constant safety focus and the program's tools and strategies provide a means for empowerment and engagement. Below are some of Covenant Health's success stories:

- In two separate cases, patients were in the operating room and ready for their procedures. Prior to TeamSTEPPS training, the surgeon performing these procedures had a history of not wanting to wait for the time out process. He requested the blade for incision, but a time out had not been conducted. The surgical technicians had not pulled the mayo stand to the field – and they informed the surgeon that the knife could not be passed until the time out was done. The surgeon looked at them, then turned to the circulator and requested a time out be conducted so they could begin. Time out protocol was performed with everyone attentive; then the mayo stand and knife were delivered to the field.
- In preparing for a bariatric surgery case, the surgical technicians noted that the patient's body mass index was 62. Because of the patient's large size, the techs were concerned whether the radiofrequency (RF) surgical sponge detection mat would pick up any retained sponge, so they tested it by placing a lap sponge in the field area and scanning with the mat. No detection of the sponge was noted. They proceeded to scan for the sponge using the wand and detection was positive. The bariatric surgeon was informed of the finding for current and future cases. Subsequently, the RF surgical manufacturer was notified regarding the circumstance for clarification on weight limit with mat use for sponge detection.
- A certified registered nurse anesthetist (CRNA) used the "CUS" strategy (Concerned, Uncomfortable, STOP – this is a safety issue) to stop a surgery after incision because the patient became severely hypotensive. After intervening for several minutes, the anesthetist was able to normalize the blood pressure. Once the patient's blood pressure was stable, the surgeons were given the OK to continue with the procedure.
- An operating room attendant went to pick up a patient for surgery, and while checking the ID band, he noted the MA number on the patient's ID band did not match with the information he had been given. He located the patient's nurse and insisted that the ID band issue be corrected before transporting the patient to the OR.
- A young woman walked into the emergency department complaining of not feeling well. She had gastrointestinal symptoms, back pain, and was "hurting all over." She appeared acutely ill and was taken directly back to a room, where her blood pressure was found to be low and her heart rate was 160/min. Intravenous fluids were started immediately and labs drawn. The RN requested the physician to order antibiotics for the patient, as she felt the patient was likely septic, considering her vital signs and elevated lactic acid level. The physician was ordering oral antibiotics and thought the patient was dehydrated from vomiting and diarrhea. The nurse repeated her concerns to the physician regarding the patient's continued elevated heart rate despite receiving three liters of IV fluid. She persisted in conveying that the patient appeared acutely ill. Orders were changed to IV antibiotics and CT scans were performed. The patient was ultimately admitted to the ICU with septic shock, was mechanically ventilated, and received large doses of vasopressors. The patient eventually reached full recovery and was discharged.

We congratulate Covenant Health on their TeamSTEPPS program successes and applaud their efforts to continually build a culture of safety. For more information on TeamSTEPPS and how Sedgwick consultants can help your team in its implementation, call us at 866-225-9951.

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In memoriam

With sadness, we note the passing of our good friend and colleague, Don Harper Mills, MD, JD, who served as our medical director for over twenty years and was a member of the editorial board for our Risk Resource Newsletter. We were honored to work with this very distinguished individual.

Dr. Mills was instrumental in the development of the tort reform scheme in California (MICRA) and participated on the committee that developed the Durable Power of Attorney for Healthcare and Directive to Physicians, widely accepted across the nation as the fundamental instruments for documenting an individual's self-determination regarding healthcare and end-of-life decisions. Dr. Mills served as an invaluable resource for our colleagues and our clients over the years, and will be deeply missed.

Upcoming events

Visit the Sedgwick professional liability team at these upcoming conferences:

- **American Society for Healthcare Risk Management (ASHRM)**
  October 27–30 | Austin, TX
  booth #517
  Sedgwick presentations:
  - Monday, October 28 | 10:15 – 11:15 am
    Driving Down Claims: Tackling the Top Ten – Ann Gaffey, RN, MSN, CPHRM, DFASHRM and Jayme Vaccaro, JD
  - Monday, October 28 | 1:45 – 2:45 pm
    Rapid Risk Assessment: Office Practice Patient Safety – Kathleen Shostek, RN, ARM, BBA, CPHRM, FASHRM and Brenda Wehrle, BS, LHRM, CPHRM
  - Tuesday, October 29 | 11:00 am – 12:00 pm
    New Risks in the Enterprise: Managing the Risks of ACOs – Barbara Youngberg, JD, BSN, MSW, FASHRM
- **Emergency Medicine Patient Safety Foundation (EMPSF) educational webinar – *register at www.empsf.org***
  November 12 | 12:00 – 1:00 pm EST
  Triage to Treatment: Avoiding Delays and Reducing Risks – Kathleen Shostek, RN, ARM, BBA, CPHRM, FASHRM and Robert Schafermeyer, MD, FACEP, FIFEM, FAAP

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Sedgwick is the nation's leading provider of technology-enabled claims and productivity management services. Our healthcare risk management consultants bring years of risk management and patient safety experience to help clients identify risk and patient safety strategies for success. Our team of national experts addresses both traditional and emerging risks affecting healthcare organizations.

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