

ACI's National Advanced Forum on Medical Professional Liability

October 30-31, 2014

Minimizing Exposure to Medical Malpractice Litigation: Implementing Preventative Measures, Reducing Risk and Avoiding and Managing Catastrophic and Mass Tort Claims

Lesli Giglio, RN, MPA, CPHRM
Director; Regulatory Affairs/Risk
Management Patient Safety
Officer; Privacy Officer
St. Francis Hospital

Michael Wong, JD
Founder/Executive Director
Physician-Patient Alliance for
Health & Safety

Jennifer L. Green
Senior Claims Analyst,
Healthcare Malpractice Claims
Department
AIG

Catherine Walberg
Senior Vice President, Physicians
Insurance A Mutual Company

Roger E. Harris
Swift, Currie, McGhee & Hiers, LLP

Tweeting about this conference?

#ACIInsurance



Drivers of Risk

- Observing Protocol
- Identifying High Risk Patients
- Ensuring Documentation is Complete
- Communication (including hand-offs communication)
- Just Culture
- Transparency (speak up and no fear of retaliation)
- Disclosure communication

Observing Protocol

- Adherence to standards helps ensure safety, reliability and consistent care



Observing Protocol – Opioid Example

- *“The Joint Commission recognizes there is an opportunity to improve care for patients by improving the safety of opioid use in acute care settings given that data show opioids are among the top three drugs in which medication-related adverse events are reported. Opioids are necessary to prevent suffering, but there are risks related to potency, route of administration, and patient history. By engaging in a comprehensive approach to assessment, monitoring, and patient education, opioid overuse and associated harm can be prevented.”*

***Ana Pujols McKee, MD
Executive Vice President and Chief Medical Officer
The Joint Commission***

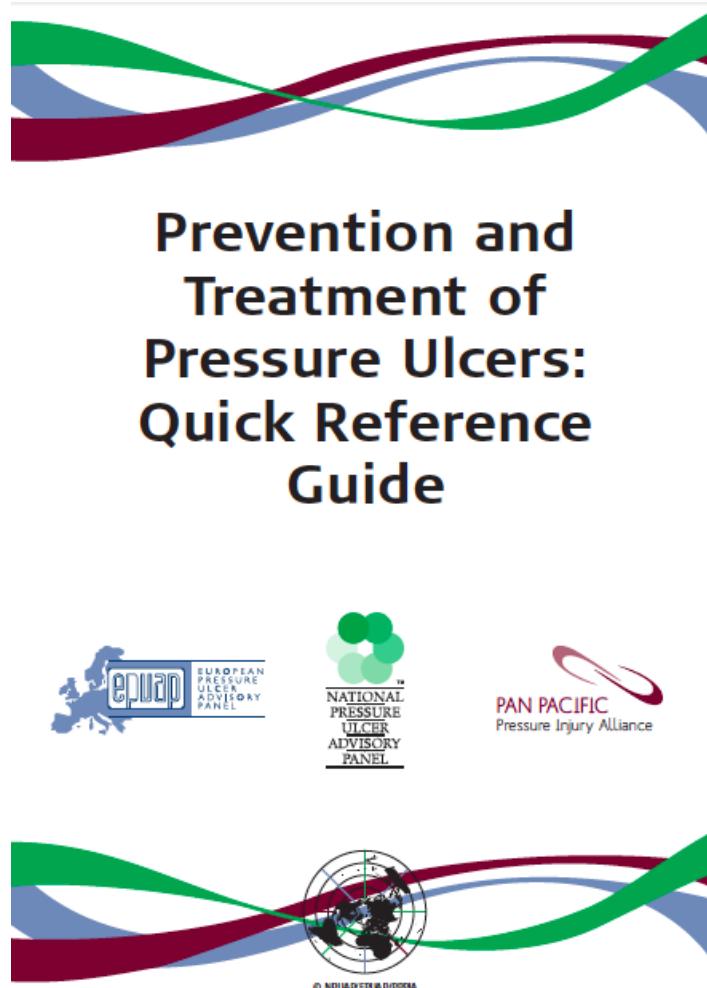


Observing Protocol – Opioid Example (PCA Safety)

| PCA Safety Checklist | Physician-Patient Alliance for Health & Safety |
|---|---|
| <p>PCA Pump Initiation, Refilling, or Programming Change</p> <ul style="list-style-type: none">■ Risk factors that increase risk of respiratory depression have been considered:<ul style="list-style-type: none">● obesity● low body weight● concomitant medications (opiates and non-opiates) that potentiate sedative effect of opiate PCA● pre-existing conditions such as asthma, COPD, and sleep apnea● advanced age■ Pre-procedural cognitive assessment has determined patient is capable of participating in pain management (note: pediatric patients may not be suitable for PCA)■ Patient has been provided with information on proper patient use of PCA pump (other recipients of information – family/visitors) and purpose of monitoring■ Two healthcare providers have independently double-checked:<ul style="list-style-type: none">● patient's identification● all patient allergies appear prominently on medication administration record (MAR)● drug selection <u>and</u> concentration confirmed as that which was prescribed● any necessary dose adjustments completed● PCA pump settings● line attachment to patient and tubing insertion into pump■ Patient is electronically monitored with both:<ul style="list-style-type: none">● pulse oximetry and● capnography | <p>PCA Pump Check at Shift Change and Every Hour Since Last Assessment (Recommended)</p> <ul style="list-style-type: none">■ Patient satisfactorily assessed for:<ul style="list-style-type: none">● level of pain● alertness● adequacy of ventilation■ PCA pump settings verified■ Electronic monitoring verified:<ul style="list-style-type: none">● pulse oximetry and● capnography■ Patient assessment/condition has been added to flow sheet/ chart documenting PCA dosing and monitoring |

THIS CHECKLIST IS NOT INTENDED TO BE
COMPREHENSIVE. IT IS A SHORT-LIST OF RECOMMENDED
STEPS TO MINIMIZE ADVERSE EVENTS AND MAXIMIZE
PATIENT SAFETY AND HEALTH OUTCOMES.

Observing Protocol – Pressure Ulcer



#ACIInsurance



Identifying High Risk Patients

- Higher the risk, the higher the potential cost/damages



Identifying High Risk Patients: Example: Maternal Patients

**OB/GYN VTE SAFETY RECOMMENDATIONS
FOR THE PREVENTION OF VTE IN MATERNAL PATIENTS**

antepartum intrapartum postpartum

Applies to: Cesarean and Vaginal Delivery

STEP 1 Admission/Transfer of Care Assess Patient for VTE Risk and Document

Risk Factor(s)
(check all that apply)

| 1 point | 2 points | 3 points | 5 points |
|--|--|--|--|
| <input type="checkbox"/> Minor surgery planned <input type="checkbox"/> Age over 35 years old <input type="checkbox"/> Prior major surgery < 1 month <input type="checkbox"/> Pregnancy or < 1 month postpartum <input type="checkbox"/> Varicose veins (current) <input type="checkbox"/> Inflammatory bowel disease (history / current) <input type="checkbox"/> Overweight (obesity BMI > 30 kg/m ²) <input type="checkbox"/> Oral contraceptives or hormone replacement therapy (history) <input type="checkbox"/> Preeclampsia (history / current) <input type="checkbox"/> Smoking (history / current) <input type="checkbox"/> Postpartum hemorrhage (current) <input type="checkbox"/> Unexplained stillbirth (history) | <input type="checkbox"/> Major surgery (> 45 min.) <input type="checkbox"/> Laparoscopic surgery (> 45 min.) <input type="checkbox"/> Patient confined to bed > 72 hrs. <input type="checkbox"/> Currently on bedrest / restricted mobility in the antepartum / postpartum period <input type="checkbox"/> Immobilizing plaster cast (current) <input type="checkbox"/> Central venous catheter (current) <input type="checkbox"/> Cesarean-section delivery (current) <input type="checkbox"/> Diabetes (including pre-gestational diabetes) (history / current) <input type="checkbox"/> Malignancy and/or chemotherapy (history / current) <input type="checkbox"/> Parity > 5 <input type="checkbox"/> Assisted reproduction (current) | Patient admitted for chronic major illness: <input type="checkbox"/> myocardial infarction <input type="checkbox"/> congestive heart failure <input type="checkbox"/> kidney disease <input type="checkbox"/> chronic hypertension <input type="checkbox"/> Severe sepsis/infection (current) <input type="checkbox"/> VTE (DVT or PE) (history) <input type="checkbox"/> Factor V Leiden/activated protein C resistance (history / current) <input type="checkbox"/> Antithrombin III deficiency (history / current) <input type="checkbox"/> Protein C or S deficiency (history / current) <input type="checkbox"/> Prothrombin 20210A (history / current) <input type="checkbox"/> Homocysteine (history / current) <input type="checkbox"/> Other congenital or acquired thrombophilia (history / current) <input type="checkbox"/> Blood transfusion (history / current) | In last month, patient has had: <input type="checkbox"/> Major surgery <input type="checkbox"/> Elective major lower extremity arthroplasty <input type="checkbox"/> Hip, pelvis or leg fracture <input type="checkbox"/> Stroke <input type="checkbox"/> Multiple traumas <input type="checkbox"/> Acute spinal cord injury (paralysis) <input type="checkbox"/> Personal or family history of blood clots or clotting disorders |

of Risk Factors # of Risk Factors # of Risk Factors # of Risk Factors

0 x 1 = 0 0 x 2 = 0 0 x 3 = 0 0 x 5 = 0

Risk Factor Assessment (RFA) = 0

THESE RECOMMENDED STEPS MAXIMIZE VTE PREVENTION, PROMOTE PATIENT SAFETY AND HEALTH OUTCOMES.
THERE MAY BE OTHER INDICATIONS FOR VTE PROPHYLAXIS THAT ARE NOT LISTED.

November 2013

AMERICAN CONFERENCE INSTITUTE

Ensuring Documentation is Complete

In reviewing my dad's medical records, I learned the nurse who had been taking care of him on the night of the 5th had not checked on him since 11 pm. There were also pertinent morphine administration records "missing" from his chart. Her documentation showed that she precharted on him; in fact you can tell clearly where she changed her time; she wrote "0500 resting quietly, NAD [no acute distress], respiration even; 600 resting quietly, NAD". Then, "report given to the next shift"; but, in reality at that time, they were transferring him to another facility because he had coded. **Malinda Loflin, RN, BSN**

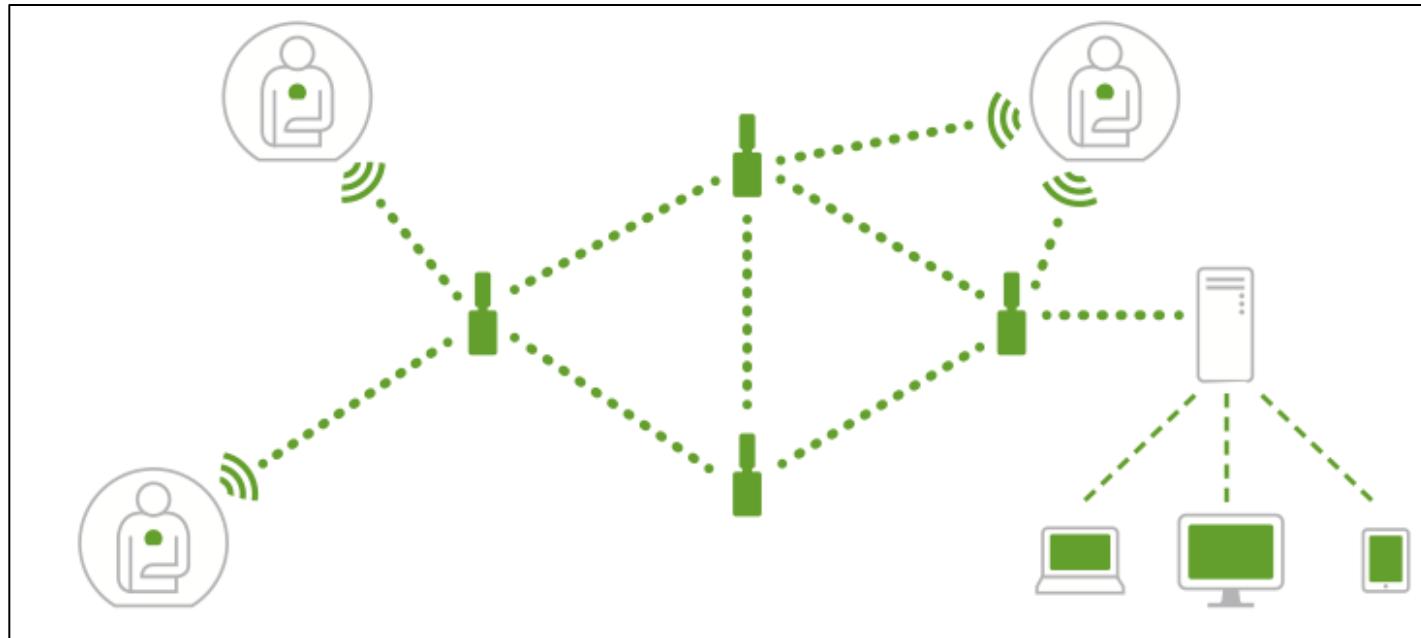
<http://community.advanceweb.com/blogs/nurses3/archive/2013/07/03/nursing-spot-checks-for-patient-safety-a-nurses-perspective.aspx>

#ACIIInsurance



Ensuring Documentation is Complete

- Pressure ulcers – was the turn documented?
- Is this integrate with electronic records?



Communication (including hand-offs communication)

An estimated 80 percent of serious medical errors involve miscommunication between caregivers when patients are transferred or handed-off.

The Joint Commission

<http://www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=1>



Communication (including hand-offs communication)

- Opioid example
- Maternal patient example
- Pressure ulcer example

Definition Just Culture

- A robust set of values, beliefs, and actions that provide solid guidance on how an organization can best manage safety.
- Safety is a primary value
- Emphasis on learning rather than blame

Just Culture – What's it About?

It's about both Error and Drift

- It's both Pre and Post Event
- It's about Leadership Commitment
- It's about Values and Expectations
- It's about System Design and Behavioral Choices
- It's for All Employees
- It's about collaboration, team work, partnership

Just Culture Model

A Model That Focuses on Three Duties balanced against Organizational and Individual Values

The Three Duties

- The duty to avoid causing unjustifiable risk or harm
- The duty to produce an outcome
- The duty to follow a procedural rule

• Source: David Marx, JD, Outcome Engineering, LLC

Organizational & Individual Values

- Safety
- Cost effectiveness
- Equity
- Dignity



Human Error

Unintentional or non-deliberate action: slip, lapse, mistake. A product of our current system design.

Manage through changes in:

- Processes
- Procedures
- Training
- Design
- Environment



Action → Console

Examples of Human Errors:

Accidentally picking up the wrong chart from a crowded counter.

Accidentally pushing the wrong button on a computer

At-Risk Behavior

A behavioral choice: risk believed to be insignificant or justified



Manage through:

- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

Action → Coach

Examples of At-Risk Behaviors:

Not Checking two (2) patient identifiers every time you are supposed to because you think you know the patient

Preparing more than one patient's medications/more than one medication at one time

Reckless Behavior

Conscious disregard of unjustifiable risk

Manage through:

- Remedial action
- Disciplinary action



Action → Punish

Examples of Reckless Behaviors:

Falsifying records.

Practicing while impaired.

Deliberately hurting a patient, e.g. hitting a patient who curses at you.



How do we interpret events?

- **What Are Our Beliefs About Risk Management?**
 - **To err is human**
 - **To drift is human**
 - **Risk is everywhere**
 - **We must support our values**
 - **We are all accountable**
 - **Success can be measured**

It's About Reinforcing Our Expectations of HealthCare Professionals

- Look for the risks around us
- Report errors and hazards
- Help to design safe systems
- Make safe choices
 - Follow procedures
 - Make choices that align with organizational values
 - Never sign for something that was not done

Facility Implementation Steps

- Educate Senior Leadership
- Conduct Culture Survey
- Gap Analysis
- Identify and Mentor Champions
- Align "Policies"
- Educate Managers
- Educate Staff
- Measure Success

Sample Just Culture Champions

- EVP-Chief Administrative Office
- Chief Medical and Nursing Officers (CMO,CNO)
- HR VP
- Director of Risk Management
- Other Respected Leaders

Patient and Family Engagement

Speak up

- S-speak up if you have concerns or questions
- P-pay attention to the care you get. Make sure medicines and treatment are correct- don't assume
- E-educate yourself about your illness
- A-ask a trusted family member or friend to be your advocate.
- K-know what medicines you take and why you take them

Disclosure: Why do it??

- It's the right thing to do!
- A culture that supports disclosure of error and open communication between doctors and their patients supports a culture of patient safety

Clinton HR , Obama B . Making patient safety the centerpiece of medical liability reform
N England J Med 2006 ; 354 (21): 2205 – 2208 .

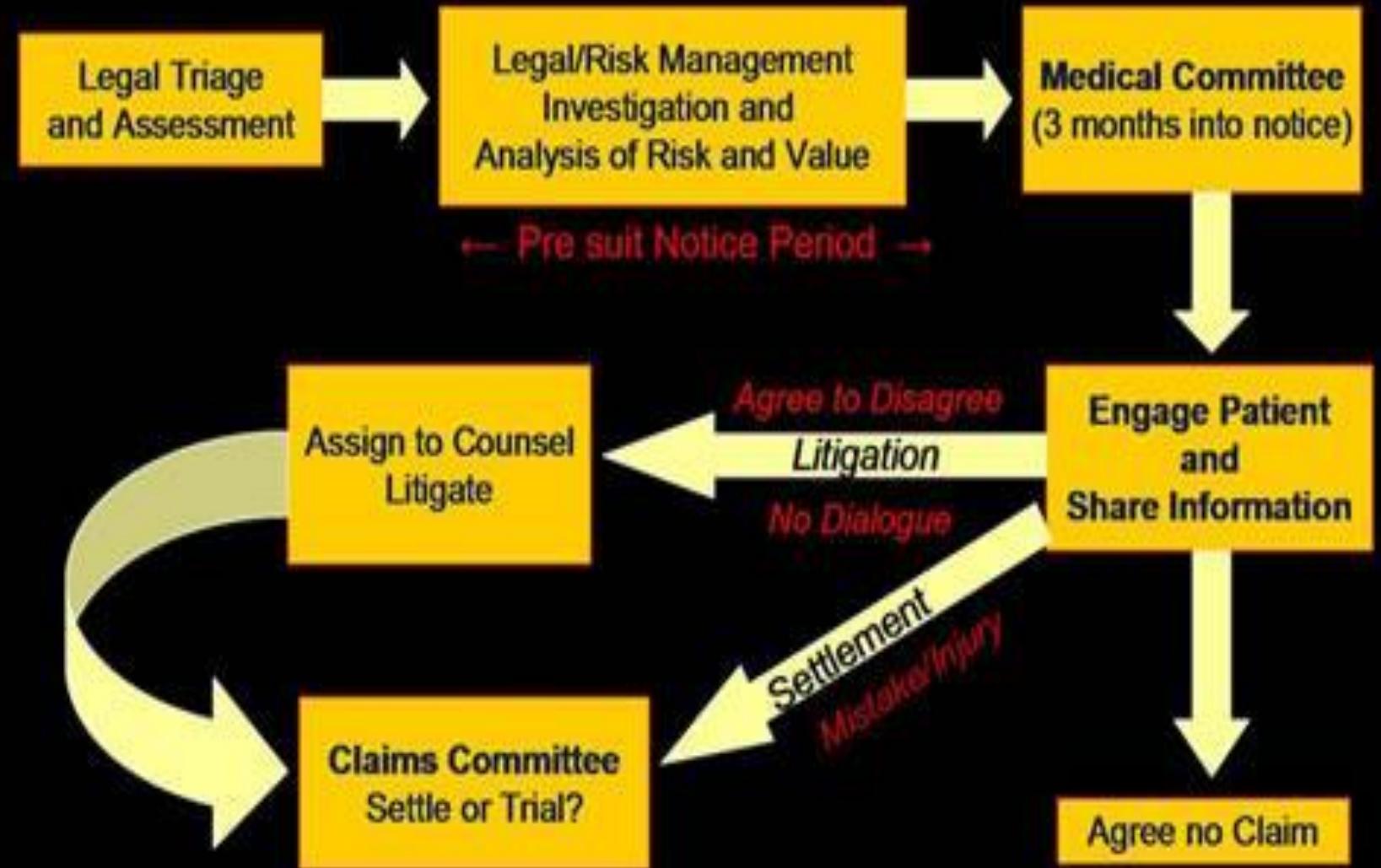
Disclosure Elements

- Explanation of the event,
- Acknowledgement of responsibility as appropriate, sincere regret
- Apology, appreciation of how the event affected the patient and family,
- Commitment to preventing recurrences, and evidence that learning occurred

Ethical Complexities in Disclosure

- Should I disclose:
 - Errors with minor/transient harm
 - Fatal errors
 - Harmful errors in patients who are hopelessly ill
 - Other doctors' errors

Present UM Claims Management Model



<http://www.uopfmhealth.org/michigan>

#ACIIInsurance



Challenges

- Fear of litigation
- Loss of trust

Michigan Experience:

Retrospective before-after analysis
1995-2007

Post program- Monthly rate new
claims 7.03-4.52/100,000 opt encounters

Avr. monthly rate new lawsuits decreased
2.13 -.75 /100,000 pt encounters

Kalachia,A et al. Annals of Internal Medicine :Liability claims and costs before and After Implementation of a
Medical Error Disclosure Program 2010; Vol. 153:4 213-222



Notice of Claim Received-Next Steps

- **Coverage Issues**

- Reservation of Rights/Denials
- Personal Attorneys
- Multiple primary carriers
 - Who controls defense?
 - What are the lines of communication and frequency of contact
 - Who pays for defense/indemnity

Notice of Claim Received-Next Steps

- **Choice of Attorney**
 - The Protection Letter
 - Public Relations Factor
 - Complex Litigation Experience/Resources
 - Ethical Conflict of Interest Consideration
 - Electronic Stored Information-Expertise/Resource



Notice of Claim Received-Next Steps

- Investigation
- Case Example #1-Hospital purchases an Ob-gyn physician practice-the cost of minimal due diligence
- Lessons Learned
 - Investigation needs to start early
 - Be creative with solutions
 - An experienced carrier is invaluable at the early investigation stage



Notice of Claim Received-Next Steps

- Consider Engaging a Public Relations Expert
 - The Media Can be your friend (sometimes)-just be sure you don't make it your nightmare

Notice of Claim-Next Steps

- **Reinsurers**

- Read the contract-what are the notice requirements?
- Establish mutual expectations regarding updates-(make them early and often-the week before mediation is too late)
- Ground rules regarding what key decisions must include the reinsurer and types of activity are “must know” from perspective of reinsurer
- Maintain rapport between reinsurer and defense counsel
- Watch-lists

Notice of Claim Received-Next Steps

- Board Communication
- Upper Management Communication
 - Consider the make up of your team-very interested or not so much
 - What critical facts or legal developments do they need to know to avoid surprising them later

There Will Be Litigation-



#ACIInsurance



Litigation & Trial – Now What?

• Initial Considerations

- Review complaint and other initial pleadings
- Discussions with adjuster
- Venue / Judge / Opposing counsel
- Client
- Multi-defendant?
- Frequent flier?
- Strategy formulation
- Teamwork / Partnership

Litigation & Trial – Now What?

- Investigation & Discovery
 - Initial strategy
 - What do we need?
 - What do we want?
 - Where is this going?
 - Strengths / Weaknesses
 - Opportunities / Threats
 - Written discovery
 - Part of the overall strategy
 - Medical records
 - Medical history
 - Current condition
 - Mine the data
 - Expert Identification
 - Standard of care
 - Causation
 - Specific issues



Litigation & Trial – Now What?

- RE-evaluation of initial strategy
 - Are you on the right path?
 - Have you anticipated where plaintiff is going?
 - No surprises
- What are co-defendants doing?
 - Communication
 - Strategy development
- Unified defense?
 - Can it work?
- Client involvement
 - Attend depositions
 - Assist with experts
 - Strategy

Litigation & Trial – Now What?

- Client Challenges

- Differences of opinion
- Stress and anxiety
- Level of involvement
 - Engaged in defense, or not?
 - Cooperative

Litigation & Trial – Now What?

- **Key Factors**

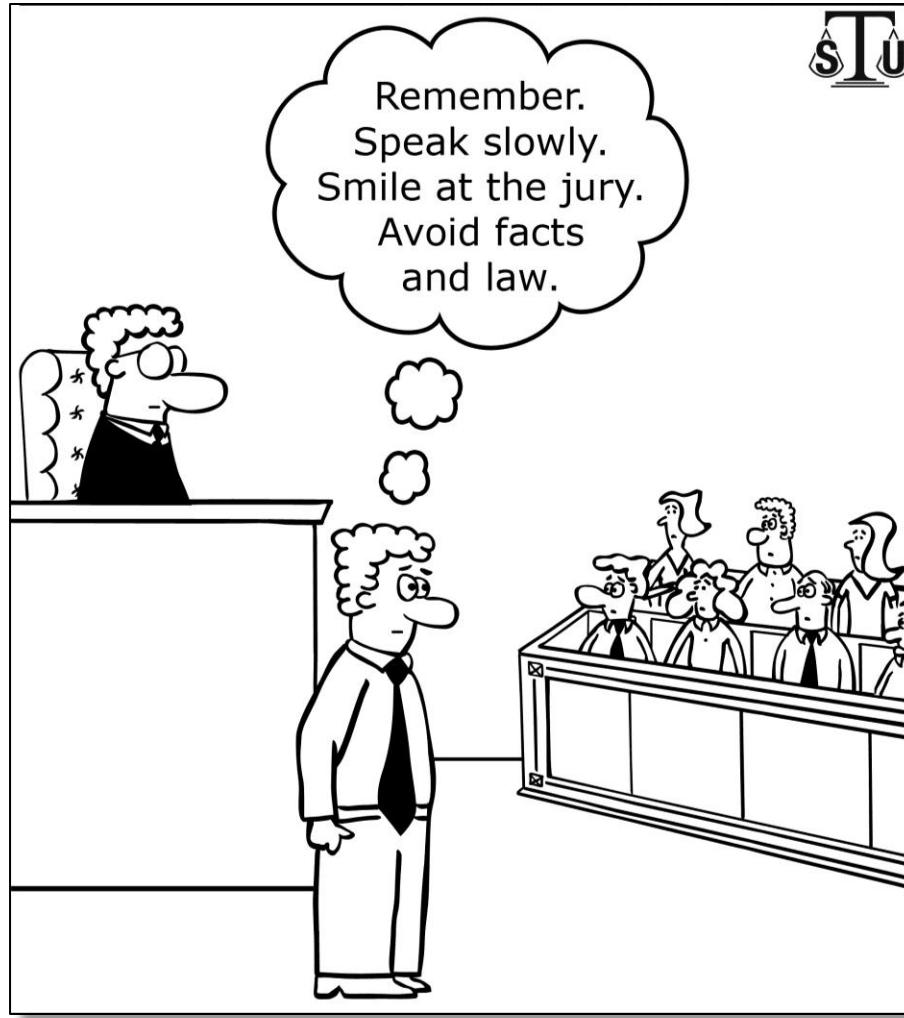
- Efficiently handling the litigation/ partnership
- Early identification of experts
- Early identification and assessment of key issues
- Appropriate and timely consideration of settlement versus trial
- Reporting
- Approvals / Guidelines
- Case evaluation
- Final decision on how to proceed

Litigation & Trial – Now What?

- **Settlement versus Trial**

- Multi-factorial, but do you have the information to make the decision?
- What does the client want to do?
- Is the client in a position to make an informed decision?
- Mediation
- Trial

When All Else Fails-



#ACIInsurance

