Risk Management at EmCare

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Context of Clinical Practice

• Societal expectations
  – IOM reports
  – Patient Safety Movement
• Tolerance for error
• Bad outcomes => bad care?
• Human fallibility
• Imperfect science
• Environment of care
• Clinical judgment
• Competing priorities
Harvard Malpractice Study
(1991)
- Bad outcomes are the main drivers of claims and lawsuits, whether the care is good or bad.
- Many patients injured by bad care never sue.
- A significant number of patients with good care and bad outcomes do sue.

Institute of Medicine Reports
- To Err Is Human: Building a Safer Health System (2000)
- Crossing the Quality Chasm: A New Health System for the 21st Century (2001)
- 9 others in the Quality Chasm series

History of EmCare’s Risk Management Program
- Original focus was EM – most experience
- Med mal expense traditionally 2nd largest business expense after provider compensation
- By 2000-2001 many of EmCare’s contracts in “crisis states”
- Aggressive focus on
  – Risk Management
  – Claims Management
Risk Management

• Activities focus on
  – Insurance procurement and related matters
  – Professional Liability, Workers’ Compensation, other
  – Management of legal claims – professional liability, etc – retaining legal help, overseeing defense strategy
  – Assisting physicians and mid-level providers involved in claims and/or government administrative (licensing and Board) actions
  – Providing information and advice to clinicians regarding legal and insurance matters
  – Addressing impaired provider issues (with HR Dept)
  – Developing and implementing strategies to improve care and reduce bad outcomes

Professional Liability Insurance

• Policies written by Continental Casualty Company, a division of CNA – A.M. Best “A rated” = financially sound
• Claims-made but we provide continuous ongoing coverage; therefore
• Physicians have no tail obligation upon departure.
• Typical limits: $1MM per incident/3 MM annual aggregate per physician

Aggressive Management of PL Claims

• New claims reviewed promptly and monitored closely by Legal Dept
• Intensive physician involvement
• Monthly review of claims with pending activity
  – Corporate executives and physician leaders
  – In-house legal counsel
  – Third party (TPA) claims administrator = Western Litigation Specialists, Inc.
Risk Management Hot Line

To report a notice of or ask a question about an event, claim or lawsuit, Board or licensing action, on-the-job injury, risk management or legal matter related to your practice:

877-667-8482

Hot Line

• Available 24/7
• Answered during regular business hours (CST)
• After hours - leave message – answered next business day

Understanding EM Claims

Frequency (Number) and Severity (Cost)

• We assign clinical categories to our claims – chest pain, abdominal pain, Non-trauma CNS, sepsis/infection, mis-read x-ray, etc
• Evaluate the claims according to 2 major factors:
  • Frequency - Number of claims related to a clinical condition or category (chest pain, abdominal pain, missed x-ray finding, etc)
  • Severity - Number of dollars paid out in each clinical category
EM Claims Experience

- Comprehensive compilation of information on malpractice claims from 1993 forward
- Proactive program designed to detect patterns in malpractice claims
- Provides a platform for giving feedback to EmCare-affiliated physicians and hospitals
- Led to development of Fail-Safe approach

Types of Claims – Hospitalist

Uncertainty due to newness of specialty and lack of classification code claims reporting (lumped in with IM, PC; EmCare has limited data).
- Medication management and reconciliation – esp narcotics
- Communication and Hand-offs – between and among like providers, consultants, personal physician; “Who’s in charge?”
- Failure-To-Diagnose and F-T-Timely Treat AMI, CVA, deterioration after surgery
- Follow-ups: Tests, after hospital care, coordination

Types of Claims - Anesthesia

Events usually known following anesthesia procedure. These events range from:
- Dental issues
- Soft tissue injury (mouth or airway)
- Medication error or reaction
- Peripheral nerve trauma
- Anoxic brain injury
- Death
Anesthesia Complications in Closed Claims Database

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>29%</td>
</tr>
<tr>
<td>Nerve Damage</td>
<td>18%</td>
</tr>
<tr>
<td>Brain Damage</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>41%</td>
</tr>
<tr>
<td>Airway Trauma</td>
<td>6%</td>
</tr>
<tr>
<td>Emotional Distress</td>
<td>4%</td>
</tr>
<tr>
<td>Eye Injury</td>
<td>4%</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>3%</td>
</tr>
<tr>
<td>Headache</td>
<td>3%</td>
</tr>
<tr>
<td>Newborn Injury</td>
<td>3%</td>
</tr>
<tr>
<td>Stroke</td>
<td>3%</td>
</tr>
<tr>
<td>Back Pain</td>
<td>3%</td>
</tr>
<tr>
<td>Awareness</td>
<td>2%</td>
</tr>
</tbody>
</table>

ASA Closed Claims N=6448

Source: ASA Closed Claims Project, DOMINO, KAREN, MD, MPH, 2007

Most Common Damaging Events

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment</td>
<td>10%</td>
</tr>
<tr>
<td>Regional Block</td>
<td>15%</td>
</tr>
<tr>
<td>Surgical</td>
<td>6%</td>
</tr>
<tr>
<td>Wrong Drug/Dose</td>
<td>4%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>23%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>12%</td>
</tr>
<tr>
<td>Misc.</td>
<td>30%</td>
</tr>
</tbody>
</table>

ASA Closed Claims N=6448

Source: ASA Closed Claims Project, DOMINO, KAREN, MD, MPH, 2007

Consequences of Misdiagnosed and/or Mismanaged Conditions

- To Patients
  - Death (~100,000 per year – IOM study)
  - Disability (estimated many more than that – IOM study)
  - Additional Medical Expenses
- To Families
  - Anger, pain and suffering
  - Fault finding and blame
  - Revenge
- To Society
  - Adversarial relationships – litigious society
  - Claims and Lawsuits
  - Defensive medicine
  - Large $$$ paid out
  - Increased costs of health care
Consequences to Providers

- Disruption of professional and family life
- Emotional impact - guilt, anger, "litigation stress", consideration to change or leave careers, cynicism
- Defensive medicine

Types of Claims—Fail-Safes

Frequent/Costly Conditions

Failure-to-Diagnose

- Abdominal pain
  - Appendicitis
  - AAA
  - Ectopic pregnancy
- Neuro
  - Stroke
    - SAH
    - Failure to Treat
  - Epidural abscess/hematoma
- Chest pain
  - AMI/ACS
- Infection-related
  - Sepsis
  - Meningitis
  - Nec Fasc/Cellulitis
  - Trauma

Chest Pain

Bedside Issues

- “Atypical” presentations are typical
- Classic presentation is uncommon, but we don’t usually miss Dx
- Clinical judgment is better at ruling in disease than ruling it out
- Education is first step but more is needed
- Guidelines and protocols improve results over clinical judgment
- Changing behavior is difficult
Abdominal Pain

Bedside Issues

- Abdominal pain is very common
- Atypical symptoms
- Abdominal pain patients are at high-risk for bad outcomes
- Abdominal pain evaluation is time-consuming
  - Risk factors
  - "Misuse" or underuse of diagnostic studies
  - UA
  - WBCs
  - RBCs
  - No HCG
  - Abdominal imaging modalities

Sepsis

Considerations in Improving Outcomes

- Sepsis, SIRS and "severe sepsis syndromes" have high mortality – a growing source of claims
- Predicting who will develop sepsis is difficult
- At-risk population is increasing rapidly – elderly, very young, immunocompromised
- Simple infections can evolve into sepsis
- Growing prevalence of "superbugs"
- Early/aggressive Dx and Rx improves outcome
- Lots of scrutiny on this problem – "Surviving Sepsis", EGDT, CMS initiatives, IHI, etc

Sepsis

Bedside Issues

- Aggressive work-ups of elderly, very young, immune-compromised
  - HIV/AIDS, Transplant, Cancer Rx, Steroid-dependent, Diabetic, CRF, etc
- Recognize signs
  - Abn VS (inc mild)
  - Potential to deteriorate quickly
- Early Goal Directed Therapy – saves lives
  - Antibiotics
  - Fluids
  - Other modalities
Stroke

**Considerations in Improving Outcomes**

- 3rd leading cause of death in US
- Lack of organized approach impedes timely and effective treatment
- Many patients still not eligible for thrombolytics
  - Recently expanded time window proposed
- TIAs need prompt, aggressive evaluation

Stroke

**Bedside Issues**

- Early recognition of symptoms
- Coordinated multidisciplinary approach
  - Starts with pre-hospital providers or at triage
  - Radiology, other diagnostics
  - Consultants, other resources
- Organized process/protocols
  - Prompt physician contact
  - Ready access to CT
  - Rapid decision to treat or transfer

EmCare’s Fail-Safe Approach
Fail-Safes (FS)

- Toolsets for improving patient outcomes in the high risk conditions
- Among the top 10
  - Chest Pain – missed and delayed Rx of AMI, aortic dissection, pulmonary embolus
  - Abdominal Pain – missed appy, ruptured AAA, ectopic preg, testicular torsion, ischemic bowel, perforated viscus
  - Sepsis & infections, including necrotizing fasciitis
  - Stroke – an organizational approach

Fail-Safe Program Components

- Education
- Prompts, reminders, standardized order sets (T –System, EMRs, CPOEs)
- Quality improvement – chart review
  - Compare care with guidelines
- Feedback to providers

Fail-Safe Program Components

*Educational Materials*

- On-line (www.emcare.com)
  - Articles
  - Checklists
  - Forms
- PowerPoint slides
- EmPressions
- Fail-Safe posters
- Data collection forms
- EmCare specific T-forms and electronic documentation
Fail-Safe Program Components

Education Program
- Discuss program at monthly meeting
- Familiarize providers & nurses and other staff with program
- Encourage use of Fail-Safe approach
- Gain Consensus of ED Clinicians
- Involve Hospital Quality Improvement Leadership - Physicians and Others
- Lead by example

Bedside interventions
- Prompts, reminders on documentation materials (T-system, EMRs, TSG)
- Standardized order sets

QI Program
- Review charts using F-S criteria
- Discuss charts as group exercise
- Provide feedback - both positive and negative - to individual clinicians
- Repeat process periodically to monitor for improvement
- Involve Hospital’s Quality Improvement Leadership and Medical Staff Peer Review Structure
- Use near misses as teaching tools
- Group and individual feedback

Feedback
- Individual and group

Fail-Safe Program
Benefits
- Evidence-based and structured approach to bedside care
- Team oriented: for use by all clinical staff - physicians, mid-level providers, nurses, aides, ancillaries, etc
- Fosters a common focus and approach
- Easy to implement; easy to use
- Reduce variations in care

Fail-Safe Implementation - 2005

- Reduction in Number of Chest Pain Claims
- Reduction in Average Cost of Chest Pain Claims
Chest Pain Fail-Safe

Lessons

- This approach can reduce bad outcomes and claims.
- Implementation of QI/PI Process and feedback to providers is biggest challenge.
- Nursing and QI involvement is key.
- Variability in how tools are used.
- Program well-received by hospital QI and RM.

When You Return

- Review the Fail-Safe materials on-line or hard copy.
- Work with your Medical Director to understand how the Fail-Safes are being implemented.
- Use the Fail-safe Approach and Tools in Daily Practice.
- Take a Leadership Role in Making and Sustaining the Change.

Accessing the Fail-Safes

- [www.emcare.com](http://www.emcare.com)
- Secure login
- Clinical Resource Center
- [https://portal2.emsc.net/EmCare/phys/defaul.aspx](https://portal2.emsc.net/EmCare/phys/defaul.aspx)
Comments
Questions

Thank you!