A Risk Management Program for Emergency Medicine; basic components and considerations

an Information Paper

Developed by members of the ACEP Medical Legal Committee

January 2013
A Risk Management Program for Emergency Medicine; basic components and considerations

an Information Paper

Introduction

Risk management (RM) is a recognized means of limiting resource losses, typically monetary assets. Initially developed and embraced by the aviation and manufacturing sectors, risk management philosophies, strategies, and tools were subsequently adopted and refined to serve the medical setting. Medical organizations have utilized various RM methods that generally focus on limiting poor patient outcomes while improving patient and staff safety. Health professionals can also learn how to successfully avoid and mitigate risk by proactively pursuing RM principles, including best medical practices, appropriate professional behaviors, and enhancing patient satisfaction. In a society where dissatisfaction with medical outcomes has great potential for professional liability, loss of reputation and potential loss of market share, realities require emergency medicine providers to work with hospital partners to enhance RM practices.

While risk management is a complicated and often resource intensive effort, some standard principles and time proven processes can be beneficial to any organization. The following outline provides information for developing and/or enhancing an emergency medicine RM program. Information provided in this outline should be used in conjunction with the planned efforts by affiliated organizations and in consultation with appropriate legal counsel. This can ensure a coordinated and cooperative effort to meet patient, facility, and provider needs that are consistent with local, state, and national laws, regulations and best risk practices.

Outline

I. Leadership
II. Department Risk Committee
III. Pre-employment screening and credentialing
IV. Orientation
V. Documentation; practice guidelines and “templates”
VI. Continuing Medical Education
VII. Quality Improvement Program
VIII. Complaint/Compliment Management Program
IX. Customer Service Training and Application
X. Claims Management
XI. Risk Management Site Assessment
XII. Peer Support/Employee Assistance
XIII. Training Facility Considerations

Explanation of Concepts

I. Leadership
Key to excellent risk management programs is leadership. Good leaders provide a vision of a solid RM program. Quality leadership also requires a top down commitment to risk concepts, ensures resources, enables dedicated time, and engenders a focus on risk that allows its principles
to be integrated into key components of a successful emergency care practice. An appropriate way to administratively structure an Emergency Department (ED) risk program is to form a departmental Risk Management Committee either alone or in conjunction with other committees ie, Quality Management.

II. Department Risk Committee
Creation of a standing Risk Committee (RC) allows an ED to transform a vision into an active program by adding structure. The RC can fulfill a mission and provide focus on risk as an important part of the practice of emergency medicine. Some of the duties and goals of this carefully structured committee include: meeting regularly to review new relevant incidents and litigation, providing ongoing leadership and focus at the provider level, establishing standards of group participation, as well as encouraging discussions of ongoing risk reduction tools and programs. The structure and membership of this committee may vary from group to group. A committed director is critical to success of the best RC but participation in the process by all providers makes a departmental program most successful. Specific RC meetings require appropriate attendance. At a minimum leadership representation (preferably the ED chair/director) along with the committee chair should be present with a predetermined agenda. Other key parties that may attend can include the Quality Assurance director, the group CEO/president, as many ED providers as is practical, ED nursing and, when appropriate, other ED staff to include consideration of EMS personnel. Others might include credentialing staff, liability insurance representatives and legal counsel when possible and reasonable. Meeting minutes should be kept and the process should be held in a format to protect the proceeding from discovery (ie, peer review/quality assurance process). This allows for more in-depth and honest introspection with less worry about inappropriate disclosures. Minutes/reporting from the process should be properly written and edited so the results can be made available to the provider group and ED staff. Goals of the committee should be to encourage active participation by the emergency provider group to guide the emergency medicine department in managing risk. Thoughtful creative work is instrumental in adapting committee actions into departmental and institutional processes. Such action might include adopting inter and intradepartmental risk avoidance policies, addressing inappropriate high risk behaviors, seeking authority in mitigation of risk after specific risk events occur, or participation for apportioning responsibility in settlements and judgments.

III. Pre-employment screening and credentialing
Just as hospitals are responsible for credentialing physician applicants to their medical staff, emergency physicians can become more involved in the screening and selection of physicians applying for employment to their group. Activities can include collecting and verifying physician records (ie, Curriculum Vitae, license, training program completion and recommendations, board certification, continuing medical education, previous employer relationships, and prior privileges with any restriction, peer references, and inquiries about professional performance). Any “red flag” issues including licensure action, aberrant professional behaviors, disciplinary actions, malpractice claims and settlement/judgments should be further reviewed and scrutinized to further assess provider risk behaviors.

Other useful information to obtain may include:
A. Current and past professional liability carriers, types of policy (Claims made vs. Occurrence), copies of insurance certificates, and requirements or requests by providers to incur “prior acts.”
B. Prior claims, outcomes, indemnity narratives including case descriptions
C. Number of open cases, and accompanying case summary, case direction, funds placed on reserve by insurer.
D. History of denial of coverage by insurance carrier
E. History of drug /alcohol use and rehabilitation, allegation of sexual misconduct or being placed under a consent order (resolution of a legal issue by mutual consent and without a judgment).

IV. Orientation
An important but often overlooked process of getting new providers properly started in the work environment can lead to significant risk issues. The nature of emergency care in complex systems, each with variable cultures, records, resources, and patterns of practice requires appropriate procedures in introducing new providers. Such orientation programs may consist of several hours to several days of a formal, preferably check-list driven introduction to the group’s mission, philosophy, culture and risk reduction practices. Though great variability exists in this process most organizations include hospital and ED policies, procedures, best practices and medical-legal land mines. Very helpful is an introduction to community expectations and perspectives for emergency services. Orientation should be required of all newly employed practitioners prior to eligibility for partnership and clinical practice. Invitations to various risk management personnel (ie, hospital risk managers and insurance representatives), to participate in orientation of new providers often goes a long way in professional relations and enhancing provider perspectives.

Orientation may also include:
A. An introduction to concepts of professionalism, team work, customer services, documentation, EMTALA, litigation processes, do’s and don’ts in high risk situations, transfer policies, available consultative services, responsibility outside of the ED (EMS, hospital “codes,” and in-house responsibilities), and peculiarities to the specific medical system.
B. Education and procedures about what to do if receiving notification of a suit, effective communications training, and skills enhancement in managing special risk issues.
C. Participating in risk reduction training, including self-assessment training and testing. These home grown or commercial resources are proven tools to enhance risk awareness and reduce risk cases. These tools are usually available through class room work or as “on-line” resources and participation can be structured to fit into variable provider schedules.

V. Documentation Issues
A well-documented chart is one of the key components of a successful defense if litigation arises and must be a key component of any risk management strategy. Consideration should be given to using standardized documentation of care. ED records are available in various forms. Whether electronic, dictation or paper, an often suggested risk avoidance tool includes a “template” medical record that assists in standardizing documentation in the medical chart including history, physical exam, diagnostics tests, differential diagnosis, medical decision making, treatments and disposition of ED patients. Very helpful is the use of “prompts” to assist providers in evaluation and documentation efforts. A “prompted” template cues providers during documentation to areas of importance and is used as a cognitive forcing strategy to enhance appropriate delivery of care and the documentation of the medical care provided. Such prompted templates can include risk-related reminders to various elements of a medical encounter, thus enhancing documentation of care provided. Uses of Electronic Health Records (EHRs) have potential positive risk reduction aspects but selection, implementation and utilization must be carefully managed. Not all EHRs are the same, and many are not ED user friendly. Input into the selection of an appropriate ED EHR is critical. Planning for implementation of the chosen EHR is important to help avoid risk situations. Appropriate training and ongoing support is even more critical as human performance
adapts to often complicated and rigid electronic documentation systems. Modification and updating of EHR templates is unavoidable to improve system flow and manage risk. A high risk interval occurs with the adoption of a new EHR until it is well established and appropriate improvement can be accommodated. Keeping ED staff aware of various risks associated with each operating system, and providing tips on how to avoid individual documentation and EHR system errors is imperative and will be a challenge for many years into the future. New concepts in risk and risk reduction relative to the utilization of EHRs have only recently been reviewed and must be an ongoing concern for health care professionals into the future. Focused partnered work with providers, ED staff, institutions and vendors is a must to help avoid future risk issues with ED EHRs.

VI. Ongoing Medical Education

In addition to orientation processes, where risk issues are emphasized, continuing medical education should include periodic reviews of appropriate administrative and compliance issues (ie, EMTALA, professional behaviors, interpersonal skills) along with high-risk clinical topics that consistently account for most ED professional liability suits (ie, chest pain, foreign bodies, fractures, abdominal pain, pediatric fever, headache, etc.) These topics can be addressed by the department based on specific needs, with lectures, written CME material, conferences and web-based interactive CME programs specific to emergency medicine. Groups may require completion of risk-related CME annually as a condition of employment, compensation, and insurability. Various ACEP resources including texts, position statements, and educational conferences provide a wealth of worthwhile and valuable risk-related materials.

A very useful tool is a group and/or facility Risk Management newsletter. An informative newsletter can be successful in communicating risk management issues to providers. Periodic “alerts” focusing on specific disease management, clinical and operational procedures, and other timely risk-related issues may be included in mailings, handouts, or posted in the ED staff lounge. These should be carefully considered to have maximum impact and written in a manner that does not describe an identifiable case or clinical situation that could aid plaintiffs in ongoing litigation.

VII. Quality Improvement (QI) Program

Quality programs go hand-in-hand with risk management programs. QI programs help avert risk through the processes of collecting data, performing chart reviews, promoting appropriate documentation in a peer-to-peer format and improving the quality of care delivery. Audits of patients’ charts with high-risk chief complaints will form the baseline for improvement interventions. When physicians actually see how their performance compares to their peers and to the desired departmental goals, they are likely to measurably improve. The goal of the program is to enhance patient care and provide consistently defensible chart documentation that represents the best in medical care provided. Good QI programs are not easy to implement and require considerable time and resources but can be rewarding in not only improving quality but reducing risk. Some suggested ideas to incorporate Risk Reduction and Quality are included in the following paragraphs. ACEP provides useful tools for establishing QI programs.

A. Chart reviews

1. All new hires – Newly hired practitioners should all have an early assessment of risk-related charting techniques with focused feedback and education about deficiencies. Review of charts should ideally be performed by the ED Medical Director or QI Director from each facility. In the best of circumstances, all evaluators should have their own charting techniques reviewed to ascertain consistency in evaluation. For routine reviews, chart sample size need not be overly large. Specific numbers of random charts per
practitioner should suffice to evaluate quality of care and documentation and to detect trends. Some organizations consider 10% of provider charts as more than adequate for routine reviews. If charting is deemed inadequate, a post-education reassessment should be performed to verify compliance and a more specific in depth review in greater detail can be conducted.

2. Random chart reviews- Useful areas to assess would include categories of documentation to include history, physical exam, ED course, medical decision-making, operational risks (ie, informed consent), appropriate use of consultants, patient disposition, and discharge instructions. A final category evaluating overall charting success can be assessed by the simple question – “Does the ED record support the documented Diagnosis and Disposition?

3. Focused chart reviews – Reviews of specific clinical issues that pertain to high-risk situations are particularly helpful through focused reviews. Examples may include categories such as specific chief complaints or final diagnoses (ie, chest pain, headache), procedures (ie, central line placement, lumbar punctures, and intubations), clinical events (ie, cardiac arrest, unexpected deaths), and administrative events (ie, inter-transfers, EMTALA forms completion, etc.).

B. Reviewers

Depending on the items selected for review, a single reviewer per topic is often most effective. This is particularly true when utilizing a standard review format and standard criteria to assess all selected charts and to obtain useful data on individual providers. This reviewer can be an interested physician, advanced practice providers (ie, physician assistants and advanced practice nurses), or even, at times, an educated coder from the billing company. The key is consistency in chart evaluation and documentation of findings. Quality review information can be integrated with Risk Management programs to ensure appropriate coordinated efforts to educate staff and reduce risk.

VIII. Complaint/Compliment Management Program

A system for the collection, documentation, investigation, and resolution of complaints is a key component of managing risk in every ED. Medical Directors in particular should assume the lead role in the management of complaints generated by ED patients, ED and other hospital staff, and “outside” medical personnel (ie, clinic staff or EMS personnel). Effective complaint management reduces the likelihood of costly malpractice suits. Content of complaints and their resolution can be appropriately included in a departmental peer review process. Information garnered can be used as a springboard for Risk Management Committee referral for analysis, education, and forwarded to insurance carriers as deemed necessary.

A key to successful complaint management is the timely identification of complaints and a rapid appropriate response to those filing the complaint. A rapid response indicates a concern and caring approach, even if only to establish rapport until a more definitive response is pending. A final follow up, where appropriate, is necessary to resolve issues with those who file complaints. Effectively implemented, this process is a useful quality and risk resource tool.

Often overlooked is the importance of recognizing compliments. Much can be learned from observations about the staff and operational components of the ED where compliments arise. Satisfied patients are less likely to litigate than patients who are dissatisfied.
IX. Customer Service Training and Application

Programs that focus on the principles of professionalism and customer service are helpful in reducing medical legal risk. Respect and courtesy to assist in providing the best patient experience possible is a proven satisfaction and risk reduction device. Demonstrating empathy is a foundation of medicine and is a useful customer relations tool. Home grown or commercial courses are available for physician and hospital personnel who interact with ED patients. The techniques of ensuring patient satisfaction require constant reinforcement – a one-time course is just a start. Any such training should consider a team approach to service since Emergency Care is a “team sport.” Increasingly hospitals and hospital review organizations are demonstrating a greater emphasis on customer satisfaction and mechanisms that prevent better patient experiences.

A patient satisfaction focus should be envisioned as a proactive mechanism to identify and create a foundation for group culture based on expectations of superb customer services. Alternatively, a reactive graduated system of focused training and feedback for physicians with identified patient relationship problems may be of help. This may begin with a nonthreatening “meeting over coffee” feedback discussion with the ED Director from which lack of improvement over time may escalate to the aforementioned special training. Key to success in this area is the consistently transmitted message that customer service is a key defense against litigation and that it is not a choice but instead an expectation by the group.

Various tools are useful in enhancing satisfaction skills. Training in “scripting” with rehearsed responses to various situations has been found to be very useful for ED team members. This scripting allows for a patient-focused response to difficult clinical situations. Proper responses and experience in scripting can reduce risk and improve patient satisfaction. Another tool is keeping patients informed (ie, waiting times), and managing expectations is critical to successful patient satisfaction. Simply expressing that individual providers “care” and are doing the best possible to assist a patient is a successful satisfaction enhancer. These tools and many similar ones are successful risk reduction devices.

X. Claims Management

No matter how comprehensive risk prevention programs are, there will inevitably be medical liability claims. Providers must know procedures to follow should they become aware of an existing or impending lawsuit. Reviewing the litigation process with providers and detailing specific do’s and don’ts are very helpful in demystifying claims and minimizing the stress of this always unwelcome event. This topic can be addressed in distributed initial orientation material and/ or discussed during the orientation process.

Although insurers, brokers and third-party administrators typically perform the bulk of claims management, emergency physicians need an organized system to handle any incoming legal notices and correspondence. The ED Medical Director needs to provide specific guidance as to how providers should respond to any legal inquiry. Similarly the ED Medical Director should establish which cases are appropriate for referral to the Risk Management Committee for evaluation and possible reporting to the insurance carrier. Procedures detailing characteristics of high-risk cases can be distributed to aid in this decision-making, and protocols can be established on how to respond to any information on possible litigation ie, legal service to a provider.

Provider groups may also choose to maintain a simple spreadsheet of suits, or even implement a sophisticated risk management information system using either homegrown or proprietary products. Information collected can be used to illustrate trends and drive the educational
programs of loss prevention. Depending on the relationship with the insurer and defense attorneys, physicians can take an active role in expert selection, deposition preparation and defense strategies.

XI. Risk Management Site Assessment
An annual review of ED processes is essential to reduce operational risks. Appropriate personnel such as the ED Medical Director, ED manager, and hospital risk manager should be included. These assessments may be conducted internally or by outside consultants. In addition to annual reviews, a regular, more frequent review should include appropriate personnel that look at issues from a risk perspective to include culture, equipment, staffing ratios, safety, behaviors and procedures that enhance efficiencies, quality and satisfaction of care. Focus on the many high-risk processes to review should, to name a few, include, triage, EMTALA, HIPAA and privacy, consent, coding and billing compliance, radiology and lab follow-up procedures, discharge procedures including patient instructions and follow-up procedures. Looking at teamwork and individual interpersonal skills as evidenced from 360 degree evaluations (each ED staff is evaluated by other ED staff in various work roles ie, doctors evaluate nurses, nurses evaluate doctors, etc.), patient concerns and satisfaction surveys can be useful. Checklists of the key areas to be addressed should be developed and followed for consistency.

XII. Peer Support/Care Team Assistance
The process of litigation is stressful and a threat to the wellbeing of most physicians. Groups may offer peer support of defendants in lawsuits, and offer professional counseling whenever necessary. Actively reaching out to make contact is often necessary to draw out the reluctant and frequently embarrassed practitioner who is the target of complaints and litigation. Communication and discussion with an empathetic listener that preferably has experienced the litigation process firsthand is desirable and frequently effective in softening the blow and confusion experienced during this often disorienting process. Care should be taken to ensure appropriate information about any case is protected from legal discovery, but this should not dissuade peers from providing general support to those involved in difficult patient medical outcomes including those involving litigation or potential risk claims. In coordination with the defense attorney, selected defendant physicians will benefit from focused deposition preparation and rehearsal provided by consultants who specialize in this service. ACEP has considerable resources to support members involved in litigation.

XIII. Training Facility Considerations
In medicine, sharing knowledge and training students is an honored tradition and fulfills expectations for physicians to assist in furthering the profession. EDs are excellent locations for health career students to be exposed to a wide variety of medical teaching cases. These training opportunities present inevitable legal risks where high patient acuity and an environment with many uncontrolled variables present a challenge to student performance and supervisory oversight. The challenges posed must be understood and carefully managed through structured risk avoidance programs.

Most institutions participate in training students after considering and implementing programs that are memorialized through carefully structured training agreements with the student’s school. These agreements typically provide for understandings and responsibilities between the school sponsoring the student and the institution where the student will train. Most of these agreements deal with administrative actions that outline what the school and training site must ensure are satisfied prior to a student rotation. Other items include expectations of student’s preparation to work in a general health care environment (ie, professional appearance, orientation to the clinical
environment, immunizations, instruction in sterile procedures, patient and student safety, confidentiality awareness, student health insurance, evaluation of student performance and expectations of student learning goals). Also included in well described training agreements is information relative to risk issues. Generally risk management provisions include descriptions of responsibility between the student’s school and the training institution for any untoward patient events involving student participation.

Physician groups and individual providers who help train students in the clinical environment must be aware of the training agreement details between the school and the training institution. Most important is to ensure that the teaching physician’s professional liability insurance covers acts by students who the providers (and group) are supervising. Any training agreement should be reviewed by the training facility legal counsel, provider group’s legal counsel and the group’s insurer to certify that malpractice policies appropriately cover the training and supervision of students. Physicians who train students should also ensure they understand the teacher and student responsibilities as outlined in teaching agreements. There should be a general understanding of the students’ goals and learning objectives and a plan for evaluating the student performance. These agreements should clearly delineate organizational and provider expectations for student supervision. There should be a mutual understanding of the student scope of practice including types of patients to be evaluated, how students should assess and present patients, limits of student responsibility, what procedures the students are allowed to perform, and what tests may be ordered. Details on how to interact with other health care team members is necessary prior to student exposure to any clinical setting. An orientation checklist of important items is a useful way for students to begin clinical rotations. This can assist providers and ED staff in understanding and in appropriately managing the activities of each student. Other areas worthy of special consideration include: defining documentation responsibilities of the trainee and a clear understanding of the supervising physician’s responsibility; educating staff to the importance of completing and reviewing specific attestation language/templates to be used by the supervising physicians; and providing adequate orientation and reinforcement to trainees and supervisors regarding their specific roles and responsibilities.

The enjoyment and responsibility of teaching raise a considerable number of potential risk situations and issues. A well planned risk process focusing on students training in the ED will improve safety and diminish the chances for student and staff generated risk issues. Teaching students can be fun and rewarding, but can also be dangerous for patients and uncomfortable for supervisors if appropriate procedures are not in place and carefully followed. This is especially true in the high risk environment of emergency care.

*Created by members of the ACEP Medical Legal Committee
September 2012

Reviewed by the ACEP Board of Directors, January 2013

Charles R. Grassie, MD, FACEP, Chair, Medical Legal Committee
Alan M. Gelb, MD, FACEP
Matthew M. Rice, MD, JD FACEP
Peter D. Steckl, MD, FACEP
Thomas E. Syzek, MD, FACEP
Marilyn Bromley, Staff Liaison*
Resources

Current ACEP references from on-line Risk Management and Resources.
http://www.acep.org/education/graduate-medical-education/academics/risk-management-outline-and-resources-for-educators/

