MANAGING RISK, MAXIMIZING SAFETY

An ISMIE report on reducing patient safety risks and exposures

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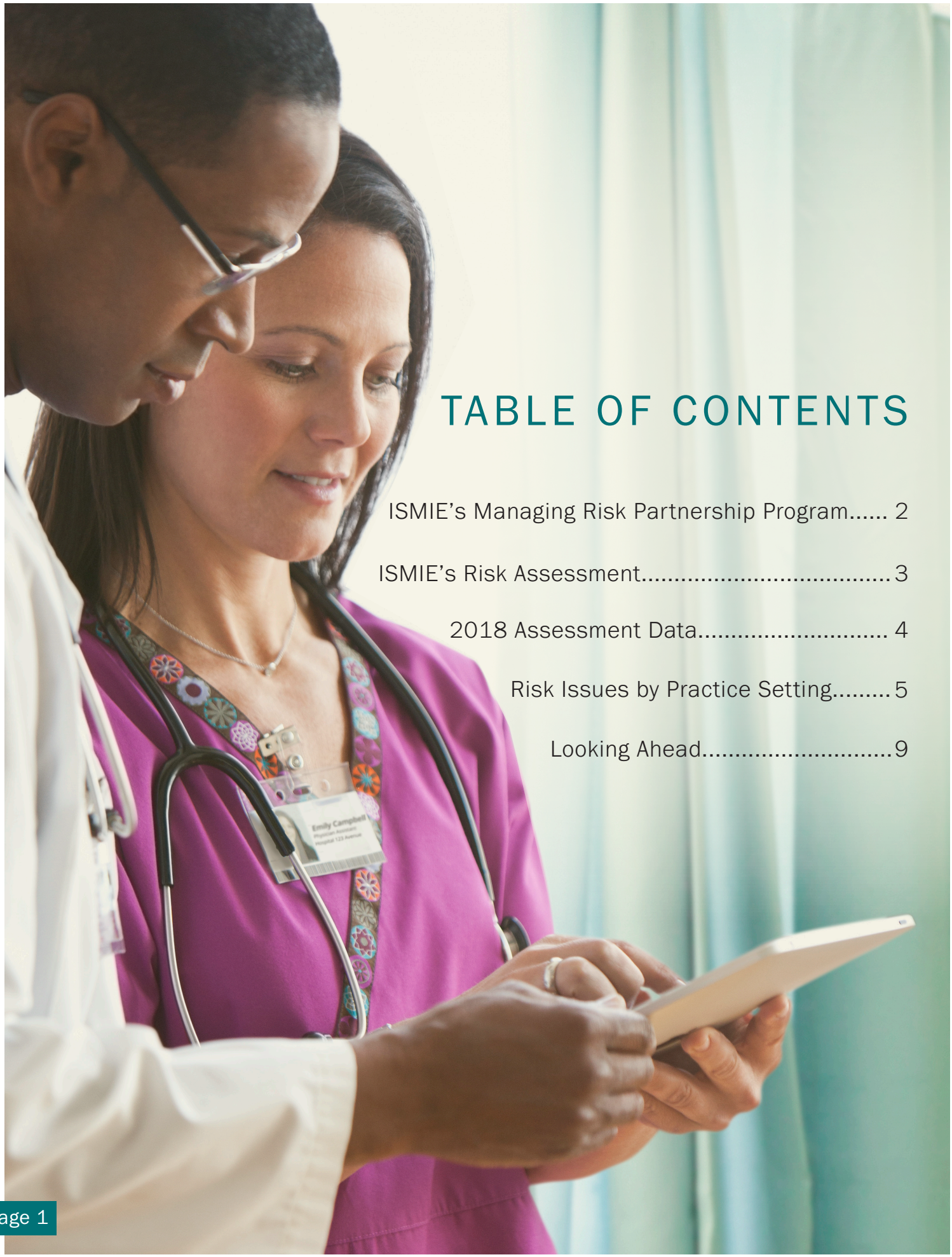

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ISMIE'S MANAGING RISK PARTNERSHIP PROGRAM

Our risk management program combines online education with personalized, on-site risk assessments to help policyholders **improve patient safety, reduce risk exposure and advance their quality of care.**

According to our most recent claims data, policyholders who fully participate in the Managing Risk Partnership Program by completing our online Fellowship coursework and undergoing a risk assessment are **37% less likely to experience a claim that results in a payment, and 21% less likely to experience a claim overall**. They are also more defensible when they are sued, resulting in indemnity payments that are 32% lower on average.

In this report, we'll take a closer look at the trends we've observed in the risk assessments that have been conducted over the past year. The primary purpose of the risk assessment is to partner with policyholders to help them better understand and address the areas of risk that may exist in their practices. Upon completion of the assessment, our risk management professionals give policyholders customized feedback on ways to reduce risk, and provide relevant resources from our large library of online courses and other risk management materials.

ISMIE'S RISK ASSESSMENT

Our risk assessment is designed to evaluate the risk management considerations associated with various specialties and practice settings, including:

- General office-based physicians and other clinicians (applicable to most specialties)
- Radiologists
- Anesthesiologists
- Emergency care specialists
- Specialists who only see patients in nursing home/long-term care settings
- Pathologists
- Urgent care specialists
- Specialists who only see patients in hospitals (e.g., hospitalists, neonatologists, intensivists, critical care specialists, etc.)

While our assessment process addresses the unique risk management considerations associated with various specialties, there are several risk management principles that are foundational for all physicians and clinicians, regardless of their practice setting. These fundamentals include:

- Thorough documentation
- Sound communication
- Effective tracking and follow-up systems

Our assessment process also outlines key practice-specific principles that, when handled well, can significantly reduce physicians' and clinicians' risk exposure. These principles are based on analysis of ISMIE's proprietary claims data and risk assessment findings, and are updated regularly to reflect industry trends and our latest insights.

2018 ASSESSMENT DATA

In 2018, ISMIE conducted 3,495 voluntary risk assessments with policyholders in 10 states. We learned that nearly all of our policyholders were applying good risk management principles in their practices, but most also benefited from some feedback on potential areas for improvement.

Common risk issues

In 2018, common issues found in assessments across all specialties and practice settings included:

- **Transitions of care.** Transitions of all types – between facilities, within a facility, and between physicians and other clinicians caring for the same patient – continue to be a significant area of risk for our policyholders. It goes without saying that communication is critically important in all transitions of care, particularly when dealing with facility transfers and discharges.

- **Electronic medical records.** These systems continue to present problems related to copying and pasting notes, use of pre-populated templates, and other general documentation inaccuracies.

- **Documentation of communication.** We noted widespread issues with communication across all specialties and practice settings. In specialties with direct patient contact, there was frequently insufficient documentation of the names of family members/caregivers involved in patient care discussions, and their understanding of the education provided.

Other issues common in many specialties and practice settings included:

- **Documentation of informed consent and patient education.** Documentation of these critical areas remains an issue. In particular, clear documentation of the patient's understanding of risks, as well as their understanding of the instructions associated with their procedure or treatment plan, is often lacking.

- **Controlled substance prescribing practices.** We have seen vast improvement in how controlled substances are managed, but use of controlled substance/pain management agreements is not yet routine in many practices. Documentation noting that the treating clinician had checked their state's prescription monitoring program was also inconsistent.

RISK ISSUES BY PRACTICE SETTING

In addition to the general risk management issues noted above, our risk management professionals observed the following trends in each of our specialty/practice areas in 2018:

Office-based

Our office-based risk assessment applies to physicians and other clinicians who see patients in a private office or clinic setting. The most common office-based issues observed included:

- **Insufficient medical record documentation:** Progress notes did not consistently include the names of family members/caregivers or other decision-makers involved in patient care discussions, nor did notes always include an indication that the patient/caregiver understood the education provided. For patients with limited English proficiency, the interpreter's name and language used was not always documented. Lastly, documentation of informed consent/refusal decisions prior to a procedure was inconsistent.

- **Issues with patient requests for controlled substances:** Processes for prescribing and refilling controlled substances did not consistently include checking the state's prescription monitoring program or documentation that the patient was educated regarding the risks, benefits, alternatives, and side effects associated with the use of controlled substances.

- **Inadequate coverage/on-call processes:** Information given and taken while clinicians were on call or away from the practice did not consistently capture all necessary details, and follow-up was sometimes inconsistent. For example, documentation did not consistently show the time of the call, demonstrate family/caregiver understanding of instructions provided, and/or note any patient instructions given (e.g., that the patient should come in the next day).

Anesthesiology

Our anesthesiology risk assessment applies to physicians and CRNAs practicing in hospitals, outpatient surgery centers or private physician offices. The most common anesthesiology issues observed included:

- **Incomplete post-anesthesia documentation:** Documentation did not consistently indicate that the patient met post-anesthesia care unit (PACU) guidelines prior to discharge.

- **Insufficient pre-anesthesia evaluation:** Progress notes did not consistently include the name of the family member/caregiver or other decision-maker involved in patient care discussions.

- **Insufficient intra-operative documentation:** Re-verification of NPO status (i.e., that the patient has been fasting) immediately prior to the start of the procedure was not consistently documented.

Radiology

Our radiology risk assessment applies to radiologists practicing in hospitals and freestanding imaging centers, as well as those who perform invasive procedures. The most common radiology issues observed included:

- **Inconsistent communication documentation:** For invasive procedures, there was inconsistent documentation of informed consent discussions. When an ordering clinician was notified of critical and/or significant unexpected findings, the name of the ordering clinician and the date/time of notification were not consistently documented.

- **Issues with over-reads, invasive procedures and pathology results:** Specimens were not consistently tracked, and radiology reports did not consistently incorporate pathology results and the name of the clinician who was to follow up regarding future care.

- **Inadequate processes for medical record security, preservation and authentication:** Radiology reports did not consistently include documentation noting that the report was final or documentation of where on the body the image was from. In addition, medical record documentation was not consistently reviewed for accuracy prior to sign-off.

Pathology

Our pathology risk assessment applies to pathologists practicing in a hospital or clinic setting. The most common pathology issues observed included:

- **Inconsistent documentation of communication:** When an ordering clinician was notified of critical and/or significant unexpected findings, the name of the ordering clinician and the date/time of notification were not consistently documented.

- **Issues with medical record security, preservation and authentication:** Amended reports did not consistently identify what was changed and were not always linked to in the original report, making it difficult to identify what was changed.

Emergency care

Our emergency care risk assessment applies to physicians and other clinicians practicing in a hospital emergency department or at a freestanding emergency treatment center. The most common emergency care issues observed included:

- **Insufficient medical record documentation:** Progress notes did not consistently include the name of the family member/caregiver or other decision-maker involved in patient care discussions. In addition, progress notes didn't consistently include an indication that the patient/caregiver understood the education provided.

- **Incomplete discharge documentation:** Discharge status was not consistently documented, and discharge instructions were not consistently communicated to the patient's primary care physician. This last issue was especially common in cases in which the primary care physician was not part of the healthcare facility or network where the patient was seen.

Hospital-based

Our hospital-based risk assessment applies to physicians and other clinicians who practice in the hospital setting managing care for hospitalized inpatients. The most common hospital-based issues observed included:

- **Insufficient medical record documentation:** Progress notes did not consistently include the name of the family member/caregiver or other decision-maker involved in patient care discussions. Additionally, progress notes didn't consistently include an indication that the patient/caregiver understood the education provided.

- **Issues with medical record security, preservation and authentication:** Medical record documentation was not consistently reviewed for accuracy prior to sign-off, and sometimes included inaccurate information due to copying and pasting.

- **Inadequate documentation for consults:** When consulting with another clinician, there was not consistent documentation of the consultant's name, the time of the discussion and the reason for the consult.

Urgent care

Our urgent care risk assessment applies to physicians and other clinicians who work in an urgent care center that is part of a larger medical clinic or in a freestanding facility. Common urgent care issues observed included:

- **Incomplete medical record documentation:** Progress notes did not consistently include the name of the family member/caregiver or other decision-maker involved in patient care discussions; up-to-date medication and problem lists; and documentation of discussions between physicians and other clinicians caring for the same patient.

- **Inadequate discharge documentation:** Medical record documentation did not consistently include discharge summaries or an indication that the patient was notified of any test results that became available post-discharge.

- **Issues with quality assurance and patient experience:** In instances in which a patient refused transfer to an emergency department, there was not a consistent process for signing out against medical advice. In addition, "urgent" versus "non-urgent" classifications were not consistently defined, and patients' conditions while in the waiting room were not consistently monitored for changes/deterioration.

Nursing home

In 2018, the number of nursing home assessments conducted was not sufficient to provide statistically significant data on common risk management issues. However, we will continue to monitor our data and share additional insights as they become available.

LOOKING AHEAD

We've recently made a few changes to our risk assessment process to address emerging risks and make the risk assessment process simpler and more valuable for participants. These changes include:

- **Streamlined criteria for pulling medical records:** For each physician or clinician, our risk management professionals now need to review just one medical record. By reviewing that patient's comprehensive medical story, our risk management professionals are able to assess how well the clinic is meeting our guiding principles.

- **New principle on physician and staff burnout:** We've encountered many instances in which poorly designed systems within practices seem to contribute to burnout, a finding backed by current literature and research. As current research also notes a strong correlation between burnt-out physicians and clinicians and patient safety incidents, we have added a section on burnout to each type of assessment we offer. So far, we've been pleased to see that many practices and facilities already have measures in place to identify and address burnout.

- **Revised report format:** We're now providing feedback to clinics and groups in one comprehensive report, rather than providing results by individual policyholder. We believe this will help clinics gain a better understanding of their risks, allowing them to prioritize where they should focus their attention and resources.

RISK MANAGEMENT RESOURCES

In addition to providing personalized feedback to those who participated in the risk assessment program, ISMIE helps policyholders reduce their risk through a robust library of online coursework and just-in-time resources. We also offer webinars and live seminars on emerging trends in risk management, including our annual Risk Management Symposium which features leading health-care and risk management experts. To learn more, visit ismie.com/risk.

Questions? We're here to help.

ISMIE policyholders who would like to request a risk assessment can do so by contacting ISMIE at (800) 782-4767 ext. 3300 or riskmanagement@ismie.com. Please note that July 1 is the priority deadline for requesting an assessment, as our risk management professionals have limited availability after this date.

For general risk management questions, policyholders are encouraged to contact us anytime at (800) 782-4767 ext. 3300 or riskmanagement@ismie.com.

ISMIE Mutual Insurance Company
20 N. Michigan Avenue, Suite 700, Chicago IL 60602 | Email: info@ismie.com | Phone: 800-782-4767 | www.ismie.com