



Client Risk Solutions | Going Beyond Insurance

Medical Group Risk: **Decluttering Design with Data**



Part I in a Series

October 2017

Abstract

PURPOSE: The purpose of this analysis is to use medical group assessment data to determine key liability risks that may result in patient harm. This is the first resource paper in a multi-part series with review and analysis of the findings. The data covers the period of 2013-2016 using information extracted from an American International Group (AIG) scored assessment tool. Questions were developed based on the potential for system defects. Clients used the results to guide redesign of processes and operations to mitigate risks. Domain scores proved useful in analyzing trends, setting priorities for consultation, and creation of new client resources.

METHODS: Analysis included data obtained from an assessment tool with 14 risk domains conducted at 35 office practices within the United States. Urgent care practices and hospital-based practices such as radiology, emergency, and hospitalist groups were excluded. The tool was developed by Client Risk Solutions (CRS) |Healthcare staff using best practice methodology. BPAs are standardized assessment tools for various healthcare facilities, developed by Liability Risk Consulting Healthcare staff. The medical group practice tool is one of several best practice assessments (BPAs) available to AIG Healthcare clients. Assessments for this sample were conducted in eight states within the United States. Resources used include published evidence-based best practices and guidelines from professional societies, government agencies and patient safety organizations. These resources include but are not limited to: the Centers for Disease Control and Prevention, American Academy of Ambulatory Care in Nursing, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, Association of Perioperative Nurses, American Society for Anesthesiologists, National Patient Safety Foundation, the Institute for Healthcare Improvement, Agency for Healthcare Research and Quality and other organizations.

Clients were asked to complete the assessment tool in advance of an on-site visit. CRS Consultants met with all levels of staff to validate responses with clients at the practice site. BPA reports feature graphic illustrations of data that clearly identify a facility's strengths, and opportunities for improvement.

RESULTS: Low scores in the majority of the risk domains indicate under-developed processes and operations in the prevention of errors that could lead to patient harm. Data has been used to identify risk management issues, develop new resources and implement meaningful recommendations in addressing risk exposures specific to medical groups.

CONCLUSION: Design of risk management programs for physician office practices remains relatively under-emphasized especially when compared to hospital settings. Our data suggests there is much opportunity for healthcare professionals to address potential errors that result in patient harm. Building infrastructures to address risk exposures *specific* to medical groups is crucial to prevent patient harm. Some hospital-physician integration models may set the stage for organizational culture challenges that impede implementation of risk management goals. While merging of both hospital and medical groups cultures have challenges and may clash, clinical and administrative leadership must share common values to achieve strategic success. Ultimately, organizational values will determine the type of resources and commitment to reduce errors that lead to harm. These values will lead to solutions built to address a variety of liability issues. It is imperative that administrative and clinical leaders collaborate to improve processes; office-based clinicians need to champion designs that lead to better outcomes. No doubt that

the solutions will require effective leadership, multi-discipline teams, patient engagement and evidence-based studies.

New CRS resources and services were created to address risk exposures as a result of the data analysis, including: development of a tool to identify risk management issues concerning medical procedures performed in office practices, development of metrics to assess impact on patient safety outcomes, and promotion of the use of the *Agency for Healthcare Research and Quality (AHRQ) Medical Office Survey on Risk management Culture*.¹

Agency for Healthcare Research and Quality (AHRQ) <https://www.ahrq.gov> accessed April 7, 2017 Medical Office Survey on Patient Safety Culture.¹

Introduction

Various studies are available that describe specific risk management initiatives that focus on regulatory issues such as Occupational Safety and Health Administration (OSHA) regulations, or Health Insurance Portability and Accountability Act (HIPAA) guidelines. However, it is difficult to find data with particular focus on risk management efforts in medical groups which include a professional liability perspective.

Data collected from 35 office practices reveal significant opportunity for the development and implementation of a risk management program for medical groups. The purpose of this analysis was to use medical group assessment data in determining key liability risks that may lead to patient harm.

Trends of Nearly 1 Billion Outpatient Visits

Medical group configuration has gone through a steady transformation in the last several years, as a large number of clinical services once provided in inpatient settings are now performed in ambulatory care settings. This growing number of outpatient procedures and clinical services are delivered in a variety of ambulatory care settings such as physician offices, hospital-based outpatient clinics, and urgent care clinics. The 2016 report released by the National Ambulatory Medical Care Survey (NAMCS), Ambulatory and Hospital Care Statistics Branch reported that there were over 922 million total ambulatory care visits in 2013 to physician offices in the United States. A little over half (53%) of these visits was made to primary care physicians.²

In addition, the last few years has shown an uptick in the physician employment model reflected in the fast pace of medical group mergers and acquisitions (M & A). The increase in the need for primary care is included in an array of organizational, operational, reimbursement and legal drivers responsible for physicians seeking hospital employment including:

- Rising healthcare costs combined with declining reimbursement
- Increased demand for primary care physicians as a result of healthcare reform
- Physicians seeking security and a work-life balance
- Physicians over-burdened by administrative duties
- Rising costs of electronic medical records and medical technology in general
- Incentives for hospitals to coordinate care and payment with physician groups
- A looming physician shortage

In certain states such as California which do not allow hospitals to employ physicians,³ the issue of consolidation can be seen in evolving medical group configurations. Regional areas may reflect this shift as solo and small groups morph into larger groups, and as single-site independent groups expand into multi-site locations.

² Ambulatory and Hospital Care Statistics Branch, 2016. National ambulatory medical care survey at www.cdc.gov; see specific data results from 2013 at https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2013_namcs_web_tables.pdf

³ Martin, Pamela and Neville, A. The Corporate Practice of Medicine in a Changing Healthcare Environment." California Research Bureau, April 2016 at www.library.cagov/crb

Hospital-Physician Practice Integration

For the last several years, healthcare industry reports have published trends on the uptick in hospital systems acquiring practices^{4/5} These reported changes coincided with our clients' request for risk management assistance. Several AIG client hospital risk managers were faced with new responsibilities of managing medical group risks.

The shift to redesign risk management programs proved challenging. Highly independent staffs of medical groups had to transition to hospital infrastructure with procedures unfamiliar to them.

The Physician's Advocacy Institute Employment Analysis

A 2016 report was produced by the Physician's Advocacy Institute in collaboration with Avalere Health, analyzed recent trends in physician employment and the acquisition of medical groups by hospitals and health systems⁶. Physicians studied in the report became employees through a group practice acquisition, or individual physicians entered into employment arrangements directly with hospitals/systems. Trends identified in the analysis included:⁷

- Between **2012** and **2015**, the number of physician practices employed by hospitals increased to **31,000**. This represents an **86%** increase over 3 years.
- By July **2015**, **67,000** physician practices nationwide were hospital-owned.
- Further, the fastest acceleration was in a **six month period** from July **2014** to January **2015** alone, with the acquisition of **13,000** physician practices.

The Impact of Aging: Who will take care of us?

Physician Shortage

In addition to the Merger and Acquisition (M & A) trends, concerns abound on how to address the growing shortage of not only primary care physicians, but the projection of physician shortages in all specialties. One report from the Association of American Medical Colleges (AAMC)⁸ provides the following projection by 2030:

- The shortage projection will reach **40,800 – 104,900** MDs in all specialties
- Primary Care MDs Estimated Shortfall: **7,300 – 43,100**
- Surgical Specialties Estimated Shortfall: **19,800 – 29,000**

⁴ Kane, C.K., & Emmons, D. W. (2013.September). New data on physician practice arrangements: private practice remains strong despite shifts toward hospital employment. *AMA Economic and Health Policy Research*.

⁵ Gallegos, A. (2012, December 10). Physician groups eye mergers but blindsided by legal fights.

⁶ Physician Practice Acquisition Study on National and Regional Employment Changes.(2016, September) physiciansadvocacyinstitute.org. accessed July 7, 2017.

⁷ Ibid

⁸ Association of American Medical Colleges, submitted by IHS Markit , April 2016. www.aamc.org. Complexities of physician supply and demand: projections from 2014-2030: 2017 Update .

Increase in Care from Non-Physicians

Nurse Practitioners (NPs) and Physician Assistants (PAs)

NPs (also known as Advanced Practice Nurses/APRNs) and PAs are expected to fill in the gaps for regions that have a shortage of physicians; much attention was paid to the NPs and PA sections of the tool for either current or future hiring plans. Additionally, it was projected that the healthcare sector will continue to experience the largest job growth in the US between 2014 and 2024:⁹

- The health care sector is projected to grow 19% between 2014 and 2024
- A portion of the growth reflects the demand for healthcare workers to address the needs of the aging population
- PAs: 30% expected job growth
- NPs: 31% expected job growth

While the intention of effective integration of NPs and PAs into our healthcare system may help the physician shortage, and in particular, Primary Care NPs, fewer than half of all states permit NPs full practice authority. However, the ACA included investments to expand the role of NPs in providing primary care. Funding was provided in amounts of \$50 million for nurse-managed health clinics, and \$15 million in grants awarded by the Department of Health and Human Services in 2012 to support 10 such clinics over three years.¹⁰ This is expected to support training for more than 900 advanced-practice nurses.¹¹

The Uncertainty of the Affordable Care Act (ACA)

The expectation of the physician shortage is amplified by growing concerns over increased numbers of insured patients due to healthcare reform. Also, possible repeal of key aspects such as pre-existing conditions continues to be headline news. A report released by Health and Human Services finds provisions of the Affordable Care Act have resulted in an estimated 20 million people gaining health insurance coverage between the passage of the law in 2010 and early 2016.¹² The study points to historic reductions in the uninsured due to:

- Medicaid expansion and Health Insurance Marketplace coverage
- Changes in private insurance that allow young adults to be covered by their parent's health insurance plans
- The plan requirement to cover people with pre-existing health conditions.¹³

Patient Age and Care Needs

However, the AAMC report noted that population growth and aging will have the most impact on increasing physician demand and note the following 2030 projections:¹⁴

⁹ Bureau of Labor Statistics. Employment projections 2014-2024 job outlook; www.bis.gov. accessed July 7, 2017

¹⁰ Van Vleet, A and Paradise, J. (2015, Jan) Tapping nurse practitioners to meet rising demand for primary care. Access: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4596547/>.

¹¹ Ibid

¹² Health and Human Services. Health insurance coverage and the affordable care act, 2010-2016. HHS.gov. accessed December 23, 2016.

¹³ Health and Human Services. 20 million people have gained health insurance coverage because of the ACA. HHS.gov. accessed December 23, 2016.

- The US population under age 18 will grow by only 5%
- The US population 65 years and older is projected to grow by 41%

Seniors have a higher per capita consumption of care resulting in higher demand of healthcare services, especially when it comes to accessing specialists.

Tool Domains

The AIG BPA for Medical Groups was used to gather information from 35 sites. The tool is intended to be comprehensive in nature supported by resources that include studies where available, standards and guidelines published and released by risk management organizations, various other organizations, as well as analysis from professional liability cases. The tool contains 130 questions divided into 14 domains (Table 1).

AIG Office Practice Assessment

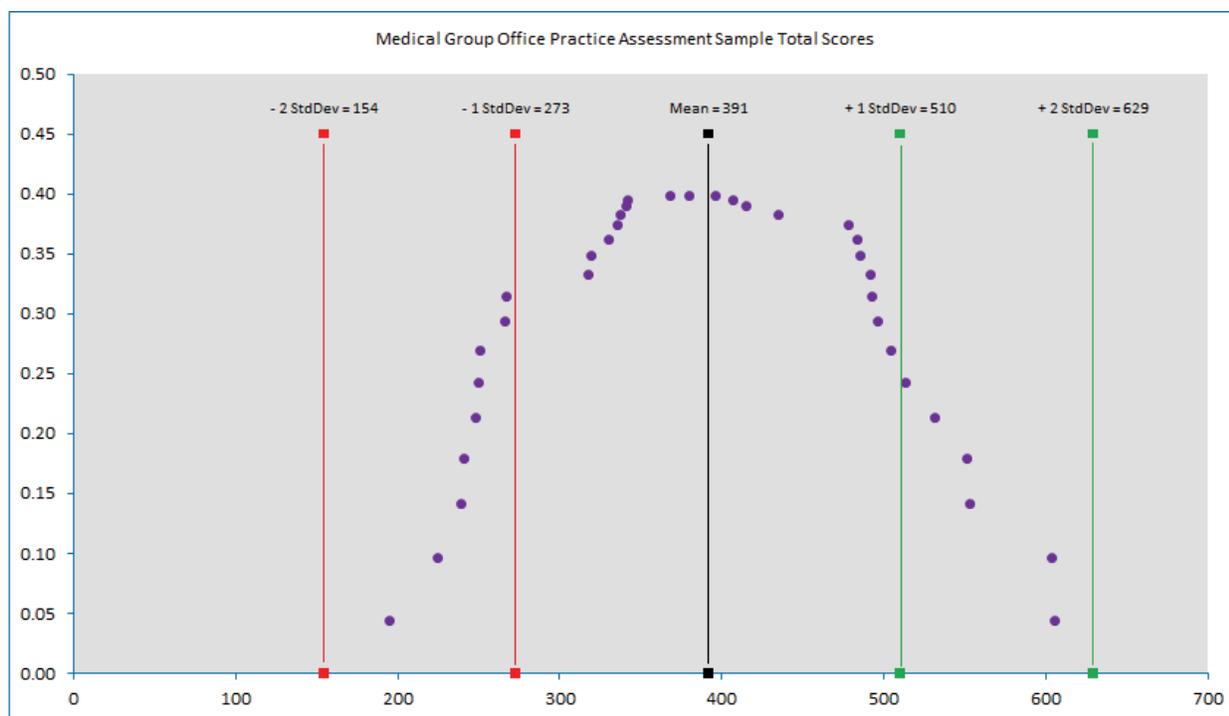
Table 1

Domain	Description
Employees	Orientation, credentialing, job descriptions, behaviors that compromise a culture of safety
Risk Management Program	Structure and process, risk management plan, just culture, staff communication
Event/Incident Reporting	Policies, training, patient complaint management, disclosure
Non-physician Staff	NPs, PAs, Medical Assistants; scope of practice, scope of duties, NP and PA credentialing, and quality measures
Clinical Practice	Credentialing of physicians, quality measures, peer review
Communications	Patient handoffs, telephone advice; mobile device use, email use
Health Literacy	Ability to review and revise patient education materials, training for staff
Tracking Systems for Follow-up Care	Procedures, policies and process for tracking diagnostic tests and subspecialty referrals
Informed Consent	Elements of informed consent discussion, informed refusal, and use of educational information
Health Information Management	Release of medical information to patients; corrections and addendums made to the medical record, training, access levels

	defined
Scheduled Medical Equipment	Tracking of maintenance of office equipment; procedures, policies, training of staff for new equipment, office inventory , documentation, sequestering defective equipment
Medication Safety	Tracking of sample medications, updates to patient records; medication reconciliation, maintenance of controlled substances
Emergency Preparedness/Medical Equipment Safety	Policies and procedures for emergencies, staff availability during office hours, conducting drills, automated external defibrillators
Infection Control and Prevention	Hand hygiene training and education; safe injection practices training and education, documentation of adherence to policies and procedures; audit tools/documentation; use of an infection preventionist

Normalized Scores: 35 Practice Sites

Table 2 - Normalized Domain Total Scores



Scores ranged from 195-606 out of a total possible score of 676. However, since not all sections were applicable to all practices, representations of total scores were normalized to provide meaningful review as indicated in table 2 “Normalized Scores from 35 Practice Sites.” Given that risk management programs in physician offices are not usually as well-developed as hospital settings, lower scores were expected. As such, clients were prepared to utilize the OPA as a template to begin constructing a Risk Management Program.

In order to provide site specific recommendations, clients complete the OPA as a self- assessment exercise followed by on-site visit by a risk management consultant. The client receives a comprehensive follow up report outlining opportunities for improvement with recommendations and references for answers that do not meet best practice. An executive summary assists clients in prioritizing recommendations.

Assessment Scorecards

Table 3 - Sample Assessment Scorecard

Qtitle	Site 1	Site 2	Site 3	Site 34	Site 35
Medical Group Office Practice Assessment v1.1	35.42	39.36	36.93	71.81	58.66
Employees	43.28	44.78	44.78	100.00	70.15
Risk Management and Patient Safety	12.50	20.83	4.17	95.83	58.33
Event and Incident Reporting	0.00	1.96	1.96	100.00	72.55
Non-Physician Staff	64.86	100.00	64.86	50.00	75.00
Clinical Practice	29.17	29.17	30.56	81.94	69.44
Communications	9.76	40.54	35.14	30.00	26.00
Health Literacy	80.00	80.00	80.00	100.00	80.00
Tracking Systems for Follow-up Care	41.18	70.59	35.29	82.35	47.06
Informed Consent	NA	60.87	21.74	91.30	82.61
Health Information Management	60.00	54.29	31.43	31.43	37.14
Scheduled Medical Equipment	12.00	NA	28.00	68.00	80.00
Medication Safety	42.86	47.62	52.38	34.62	28.57
Emergency Preparedness/Medical Equipment Safety	51.35	22.73	86.49	92.31	96.15
Infection Control and Prevention	36.26	38.05	27.36	64.89	47.87

Key:

Green = score is 100%

Yellow = score is 50% to 99%

Red = score is less than 50%

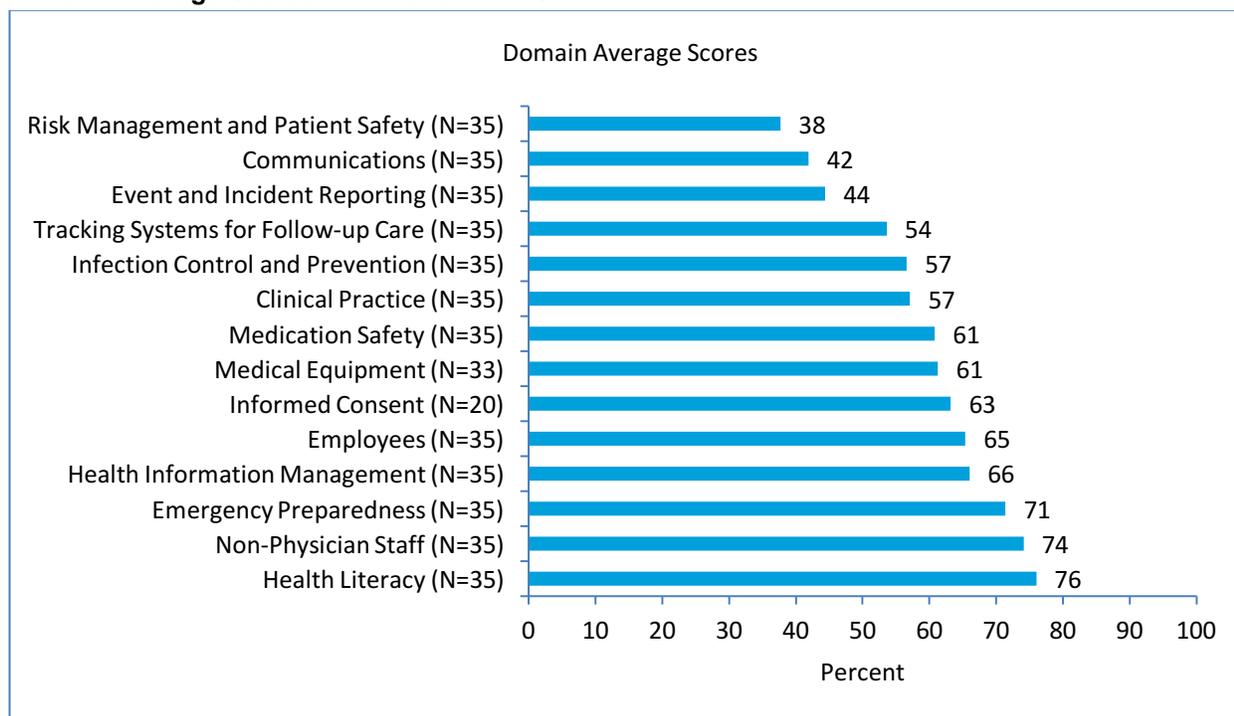
NA = the question does not apply to the office practice

Clients with multiple practice sites are able to benchmark comparisons within their healthcare system. In these instances, a selected number of sites were assessed (for example 3 out of 50 sites within an integrated delivery system). The findings from these visits reviewed for potential applicability to all locations within the system. Scorecard representation for clients is helpful in discussing inconsistencies that could be quickly identified by use of a snapshot as suggested in the *Table 3* with sites 1-3. Additionally, representative sample of all sites in AIG database is provided to clients for comparisons at the answer detail level.

Finally, certain metrics are selected to track improvements in system processes and patient outcomes. As such, there is an ongoing long-term commitment with clients to collaborate with CRS Consultant staff which adds value to clients' ongoing risk management efforts.

Risk Management Opportunities

Table 4: Average Scores: All Risk Domains



Low scores in the majority of the risk domains (*All Average Domain Scores, Table 4*) indicated under-developed processes and operations in the prevention of errors that could lead to patient harm. Data has been used to address risk management issues, develop new resources and assign long-term metrics in analyzing risk exposures specific to office practices. It is beyond the scope of this paper to address *all* domains and recommendations. However, certain domains were chosen to illustrate that much opportunity is available to develop risk management initiatives in medical groups. Subsequent resource papers in this series will provide analysis for other domains.

Risk Management Program Gaps

Few practices in our sample had formal structures to address assignment of responsibility for risk management initiatives in the physician office. Low scores are understandable, given that many risk managers with work experience solely for hospital programs, found that they were suddenly in charge of several medical practices. The lack of an overall infrastructure meant low scores for several domains. As an example, the average score for the **Risk Management** domain was low scoring since few clients had a written risk and risk management plan, nor assignment of responsibility of risk management initiatives at the practice sites.

In fact, key respondents (risk managers, risk management officers or practice administrators) communicated that the OPA offered them an opportunity to introduce themselves for the first time to the practice staff and physicians. This reflected the fast acquisition of medical groups by many healthcare organizations in many regions. In some cases, temporary assignments were made to hospital staffing

after M & A deals. One of the risk managers affiliated with a three-hospital system shared with us that she was given new temporary responsibilities for implementation of a risk management program for 28 practice sites that comprised their medical group. These responsibilities were added to her existing responsibilities for the three hospitals. Hospital leadership soon realized that no one person could handle the job. Several risk manager positions were added over the course of 2 years to address the needs of multiple practice sites.

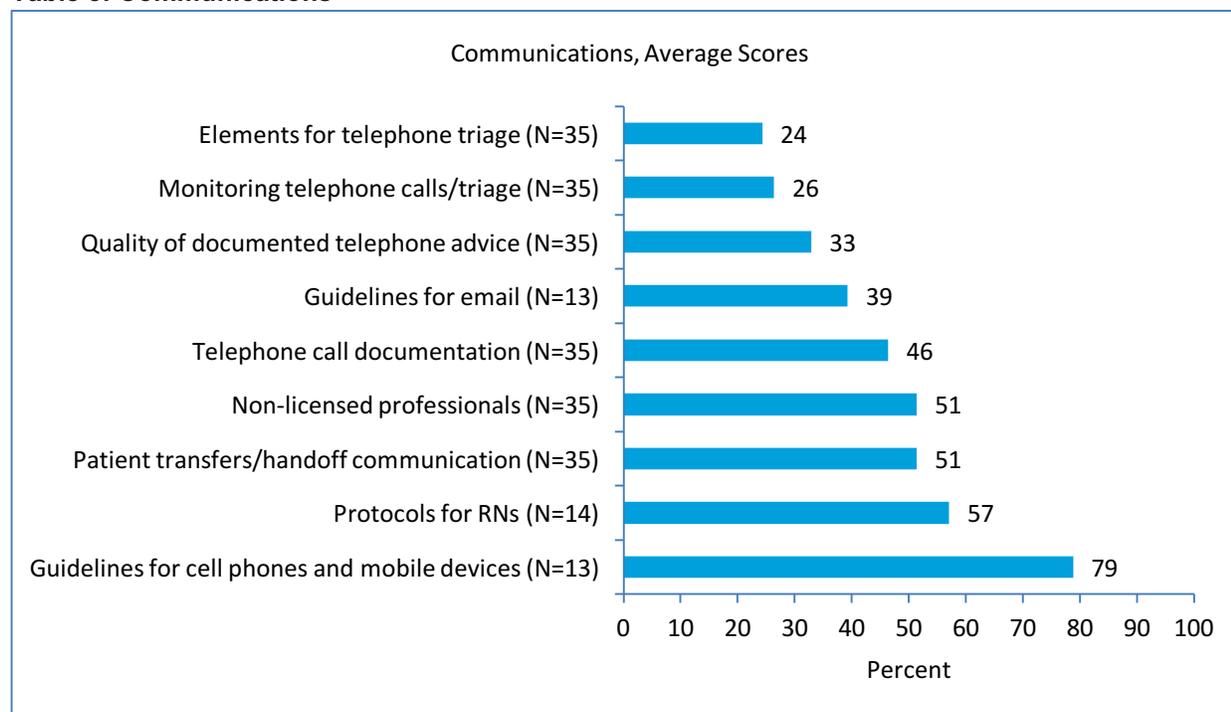
Begin with the Basics

As many of our clients noted, they were “starting with basics” in the building of policies, procedures, processes and lines of authority. Some of the hospital policies that we reviewed did not have application to medical offices and therefore were dismissed by office personnel. For example, a chain of command policy referencing a first contact as the hospital Chief Nursing Officer was not relevant to this particular organization’s office practices. Staff noted that they the process was to contact a Clinic or Site Manager. As a starting point, some of the key recommendations made to clients were very straight forward:

- Implement a risk management plan specific to medical groups
- Assign responsibility for the risk/risk management program
- Identify priorities for tracking, trending and reporting on risk management initiatives
- Establish standing agenda items for all practice staff meetings(clinical and nonclinical),
- Track ongoing risk and risk management endeavors, including progress and set-backs

After delivering OPA results to clients, AIG Consultants continue assistance as needed to support clients in launching new risk management programs as well as provide resources and information for specific risk domains.

Table 5: Communications



Communications Domain

Telephone Communications

Communication and documentation for telephone medical advice and triaging of calls prove to be a challenge for many practices. As indicated by the Table 5, *Average Scores for the Domain Communications*, the quality of documented telephone advice is rarely reviewed (**33%**) with little attention paid to key aspects of telephone documentation (**46%**). Only a total of 14 of the 35 sites used RNs to perform telephone triage; and 8 (**57%**) of those sites had telephone protocols in place for RNs to provide medical advice to patients over the phone.

Telephone triage or the provision of telephone advice, is a component of telephone nursing practice that focuses on assessment, prioritization and referral to the appropriate care.¹⁵ As such, it should be viewed as an interactive process between nurse and client that occurs over the telephone, involving the nature and urgency of client health care needs and determining appropriate disposition.¹⁶

Blurred Roles

Medical assistant (MA) staffs are key members of the healthcare team when utilized appropriately within their scope of service. However, since MAs are unlicensed assistive personnel, when their job responsibilities inappropriately mirror the duties of a registered nurse (RN), the chance for error increases with potential for patient harm. Even use of what is perceived as “simple” decision screening grids is allowing medical assistants to collect medical data or symptom-based information in the provision of medical advice over the telephone, inadvertently misleading patients whom may assume they are speaking to an advice nurse.

Recommendations for Telephone Communications

Recommendations to improve the quality of advice provided to patients over the phone include:

- Utilize written protocols appropriate for the type of practice (adult, pediatric, etc.)
- Prohibit medical assistants from giving medical advice
- Conduct systematic and ongoing criterion-based evaluation of telephone advice and documentation
- Require staff to wear name tags with titles to avoid miscommunication to patients about the role of medical assistants
- Consider utilization of a Call Center staffed with RNs, to address consistency of staff and quality of information
- Increase number of same-day appointments to avoid need for gate-keeping in appointment booking
- Periodically evaluate the quality of medical advice provided over the phone through documented review of direct observation, periodic medical record reviews

Web Portals, Emails and Mobile Devices

Many practices do not allow communication between clinicians and patients via email or use of mobile devices (Table 5). However, we felt it important for them to address this area especially since several

¹⁵ Rutenberg, C. (2010, August). Telephone triage. (Powerpoint slides). Retrieved from AIG webcast.

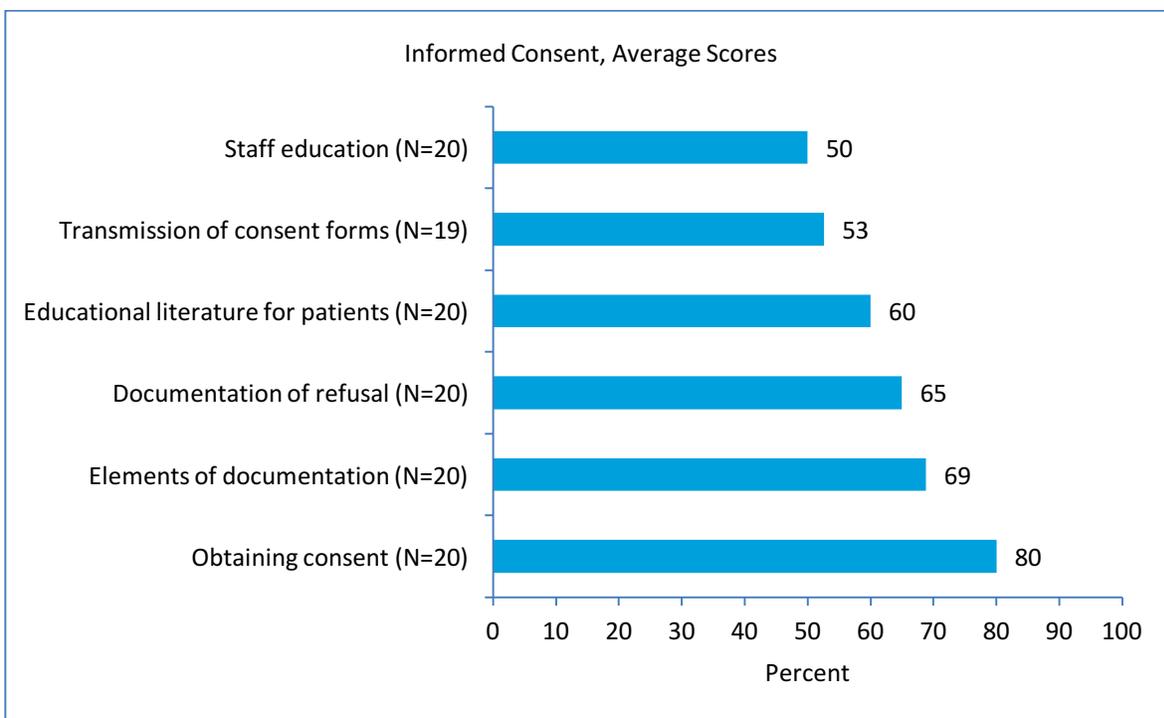
¹⁶ Ibid.

clients were in the initial stages of planning patient portals where physician-patient communication is very likely in the near future. As noted in Table 5, few sites had guidelines for email use between clinicians and patients: 13 of 35 sites used email to communicate with patients. For those 13 sites, 39% was the average scores for inquiries to this section of the tool. Guidelines for this section of the tool included: patient guidelines for email use, clinician turn-around time for replies to patients, types of email communication, limitations of email use, conditions of terminating email, prohibited subject matter (HIV, mental health, etc.) Also, when 13 of the 35 sites indicated physicians use web-based or electronic devices to communicate, 79% was the average score for inquiries to this section of the tool regarding written guidelines for cell phones and mobile devices. Guidelines involved requisite privacy training for staff, security of patient information, inappropriate use of photos, private location of taking calls, and password security.

Many clients noted that implementation of guidelines for the use of mobiles devices speaks to media attention to this topic. High profile media stories about breaches of privacy involving well-known celebrities has increased awareness about allegations of patient confidentiality breaches, lack of informed consent, suspension of Centers for Medicare and Medicaid Services (CMS) licenses and various reputation risks. As such, this continues to be an ongoing area of concern because of the advances of technology and high use of personal devices.

Becoming More Informed about Informed Consent

Table 6: Informed Consent Domain



As with our other best practice tools, the OPA had a pilot test phase to gather feedback on relevancy of tool questions prior to final release. During this draft phase, we considered deleting the informed consent section because we thought the questions would be less discerning than other sections. Questions were retained in order to verify our predictions. Contrary to our predictions, this section had lower than anticipated scores as shown in Table 6, Informed Consent.

Key issues included: an inability to consistently document risks, benefits, alternatives to treatment (**69%**); gaps in documentation of the consequences of refusing a recommended procedure or course of treatment (**65%**), and lack of staff education (**50%**). Also, when informed consent discussions were initiated in the clinic settings, informed consent materials were not consistently transmitted to hospital settings, reflected in an overall average score of (**53%**) for that question. Note here that not all 35 offices responded since they could opt out by answering no to the question: *“Are any invasive procedures or other treatments that carry a material risk of harm performed in your office practice/clinic?”*

Copy and Paste, then Paste Again

Assessment sections about medical procedures and patient complaints lead to site discussions concerning content errors. Frustrated clients provided examples of documentation errors from content imported technologies (CIT). Simple copy and paste functions have evolved into a various techniques to include templates, automated data points and cloning. The term “cloned documentation” is in reference to the repetition of identical notes recorded over the course of managing a patient’s illness. Efficiencies may be gained in following stable patients with chronic diseases. However, these gains are negated when information does not reflect a patient’s current clinical status and plan of care. Physicians, NPs and PAs all expressed concerns over several record integrity issues. In addition to copy and paste issues, problems were revealed with incomplete or erroneous problem lists. Updates to complex problem lists, and corrections, or addendums to patient chart notes throughout the day lead to long patient wait times. High frustration was expressed by clinicians and support staff when we discussed these problems. Our client discussions concerning documentation problems are consistent with issues noted in publications from various organizations such as:¹⁷

- Vital signs that never change from visit to visit
- Information copied and pasted from a different patient’s record with the wrong gender
- Identical verbiage used repeatedly for all patients seen by a provider for a specific timeframe with little or no modification regardless of the presenting problem or intensity
- No pain assessment when record includes a record of pain
- Errors in medication and allergy lists
- Repetition of irrelevant clinical information
- Excessively long notes distracting reader from key facts

Additionally, copying and pasting problems were reported anecdotally as creating problems in the patient’s record. As one example, a chart review based on a patient complaint, revealed a CIT issue in

¹⁷ Weis, Justin, MD and Levy, Paul, MD, (2014, March). Copy, paste and cloned notes in electronic health records: prevalence, benefits and best practice recommendations. Accessed: <https://psnet.ahrq.gov>.

the clinic notes and the informed consent form. The clinic note indicated “ACL tear on the *right* knee.” This documentation was in contrast to the surgical informed consent form which incorrectly indicated that the tear was on the *left* knee. Fortunately, the error was caught prior to surgery. Changes were made to the “fill in the blank” aspect of the forms and use of documentation templates. As noted below, implementation of EHRs have resulted in both dissatisfaction with unanticipated consequences and satisfaction with planned improvements.

Educational Handouts

Positive aspects of EHRs reported by several clients included the ability to have many educational handouts integrated with specific diagnoses, treatment plans and procedures so that information is generated automatically at the time of the visit. Also, materials can be generated in various foreign languages to accommodate regional populations.

Recommendations for Informed Consent and Documentation Issues

Potential solutions in addressing problems are as follows:

- Provision of Clinician Education:**¹⁸ Education on requisite information regarding benefits and risks, and alternatives to a particular procedure or treatment is needed. In particular, our clients reported ongoing reluctance on the part of clinicians to indicate *death* could be a consequence of not following the clinician’s advice (informed refusal). Many clinicians felt it unnecessary to frighten or upset patients; others felt it was obvious from the patient’s diagnosis with no need to document the risks of the patient’s refusal since common sense should prevail. Lack of documentation is problematic since after a patient death, the family may allege that the patient was not fully informed of the risks of disregarding physician’s advice. An example of this may involve a patient refusing her physician’s recommendations for oncology treatments, choosing to substitute alternative treatment of special diet and nutritional supplements. Should the family blame the physician for inadequately informing the patient of the risks of refusal, sparse or no documentation may make defense difficult.
- Medical Record Audits:** Conduct proactive periodic audits of charting practices. While controversial, clinician performance objectives might be considered especially when documentation issues are not being resolved through other means.
- Peer to peer feedback:** Clinicians need to influence change by addressing their peers, in real time, in informal ways and provide examples of problems created by poor documentation that may be found when clinicians are covering for one another in clinics.
- Use of standardized forms:** There should be emphasis on the informed consent discussion itself, rather than an overemphasis on patient signatures on informed consent forms. Risks and benefits about a procedure, treatment or medication need to be tailored to each patient. Medical groups that develop their own forms should make every attempt to clarify any language that is too complicated for an ordinary person to understand. Both legal and medical jargon should be avoided in favor of clear direct language. Ongoing education for staff should occur regarding the ethical and legal obligations of the informed consent process, use of the form, and any regulatory exceptions to obtaining parental consent. Medical group leadership should consider developing a method for ensuring up-to-date resources on consents and release of information. Appropriate sources include your state’s Department of Health, Medical Group Management Association (MGMA), your state’s hospital association, the Joint Commission or other accreditation entities, medical specialty organizations, and any other appropriate professional organizations. Again, it is important to remember that consent is

¹⁸ AIG Client Risk Solutions. Understanding informed consent in medical groups. (2010)

not a signature on a form. Consent is a continuing process of making clear the risks, benefits and alternatives of medical care in the discussion between the clinician and patient.

- **Patient Engagement:** Educational materials along with informed consent forms should be used to enhance the discussion between clinician and patient. Patients are part of the shared decision making process with their clinicians regarding the path of care. Patients and families should be encouraged to ask questions about recommended procedures, treatments and medications.

Barriers to Event Reporting

Table 7: Event/Incident Reporting



Event reporting was another area that we found particularly challenging with the majority of the section scores falling below averages of **50%**, **Table 7**. Several of our hospital accounts found the event reporting systems did not accommodate the needs of a physician practice. Some systems collected information for medical offices by use of an electronic department module as part of the electronic hospital event reporting design. However, those hospital systems collected all office events by aggregate only, with an inability to sort by office site location. Also, several enhancements or add-ons to some EHRs were not anticipated until after the M & A. The changes for EHR enhancements often required additional funds causing delays for months or years, proposed at future budget cycles. Also, some clients augmented EHRs with paper event tracking systems and understandably were frustrated by inefficiencies in doing so.

Further, several risk managers needed to introduce basic training on event reporting, including what, why and how to report. Not surprisingly, medical groups were reluctant to report unless an incident would lead

to a claim. Several of the risk managers started a Monday morning meeting for identification of reporting “good catches” to promote conversations and ultimately trust about reporting near misses.

Also, we found that policies had not been adapted to address reporting of office based events. Not only did the examples not make sense to the office staff, the events listed were oriented to the hospital e.g. hospital falls, wrong-site surgery, etc.

Recommendations for Event Reporting

Considerations should be given to the following in initiating event reporting requirements for medical groups:

- Implement policies and procedures to address what, when and how to report events
- Include transparency and just culture principles as part of organizational culture to promote reporting. Consider completing the AHRQ Medical Office Survey on risk management culture
- Schedule a Monday morning “good catch” phone meeting with multiple sites to provide positive feedback in support of reporting of near misses. Tracking and reports of improvements should include staff recognition and tracked as part of risk management initiatives.
- Implement daily huddles to increase team communication, enhance continuity of care, and to identify near misses as part of team learning to enhance patient care
- Require specific education and onsite trainings as part of ongoing staff competencies
- Work with IT to ensure the existing hospital event reporting system can be adapted for medical groups; adding information to a platform established to address the needs of a hospital unit may not provide all needed report functionality for an office practice

Office Based Medical Procedures: Post Acquisition Surprises

Frustration expressed by a number of clients indicated there was a lack of knowledge regarding types of clinic medical procedures performed in office settings. A common reason for the gaps in knowledge was that most risk managers were not involved in the due diligence process when acquiring medical groups. Risk managers discovered on a *post-acquisition* basis what type of procedures were being performed. Post-acquisition communication concerning procedures included: event reporting, inquiries made about new equipment purchases for procedures, inquiries about billing codes that matched new procedures, and requests for centralized corporate informed consent forms. As examples, one risk manager received a request from a family practitioner for informed consent forms related to various dermatologic procedures; another risk manager received a request to borrow cautery equipment from the hospital for temporary use in their office practice to perform various procedures. In response to this increase risk exposure, we have developed new assessment tools for procedures performed in the office setting.

Organizational Values, Resources and Design

Some hospital-physician integration models may set the stage for organizational culture challenges that impede implementation of risk management goals. While merging of both hospital and medical group cultures have challenges and values clash, administrative and clinical leadership must share a common vision to achieve strategic success. Ultimately, organizational values will determine the type of resources and commitment to reduce errors that lead to harm.

Design of risk management initiatives for physician office practices remains relatively under-emphasized especially when compared to hospital settings. Our data suggests there is much opportunity for

healthcare professionals to address potential errors that result in patient harm. It is our belief that resources provided to medical groups within a hospital system will improve approaches to manage risk exposures.

Design Perfection

Understanding risk exposures *specific to workplace culture in medical groups* is crucial in developing infrastructures to prevent patient harm. Any approach must assume “the workplace culture should be built to produce the outcomes you intend.”¹⁹

What are the perfect solutions? Design perfection in healthcare systems doesn’t exist. It is imperative that administrative and clinical leaders collaborate to improve processes; office-based clinicians need to champion designs that lead to better outcomes. No doubt that the solutions will require effective leadership, multi-discipline teams, patient engagement and evidence-based studies.

Future Development

In the spirit of continuous improvement, suggestions to enhance the office practice assessment tool and consultative process include:

- Utilize a culture of safety questionnaire with all medical groups receiving consultation. A baseline of staff perceptions provides information on opportunities toward building a culture of safety. We promote use of the *AHRQ Medical Office Survey on Risk Management Culture*
- Increase questions in Emergency Preparedness section of our OPA tool to address active shooter policies and drills in addition to weather based drills such as hurricane, earthquake, flooding, etc.
- Expand additional resources for diagnostic errors (currently underway) in office practices
- Develop resources for tracking of geriatric patient falls in offices
- Provide resources on risk and patient issues for obese patients in the office setting
- Involve risk managers in the due diligence process *prior* to acquiring physician practices
- Implement a policy and process to address feasibility and quality of moving medical procedures from the inpatient setting to the office setting
- Modules for the use of local or moderate sedation were developed as compliments to the main Office-Based Procedure Assessment

¹⁹ Outcome Engenuity. Workplace accountability and Reliability Training. Accessed: <https://www.outcome-eng.com/>

About the Author

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Margaret Ramirez, Director Project Management and Strategic Initiatives, AIG Client Risk Solutions|Healthcare, has developed risk and risk management programs for over 20 years nationwide. Ms. Ramirez is responsible for a number of strategic initiatives and projects for healthcare clients and has particular expertise in the delivery of services to large medical group clients.

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