TOP TEN:
PATIENT SAFETY AND RISK MANAGEMENT IN FAMILY MEDICINE

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has nothing to disclose.

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LEARNING OBJECTIVES

At the end of this activity, participants should be able to:

- Associate and Describe different facets of communication which leads to liability claims or patient safety breaches; including EHR's, informed consent, and radiologist clinician communication.
- Appraise and synthesize the experience of communication and resolution programs, particularly the experience of the COPIC 3R's program.
- Recognize and evaluate certain problem areas; including high dose opioid patients, difficult patients and noncompliance.
- Review and summarize current high risk clinical areas such as acute neurologic conditions.

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LEVELS OF EVIDENCE

COPIC CME has designated 3 Levels of Evidence for CME presentations:

1. Evidence mainly from randomized or non-randomized, well designed controlled trials; well-designed cohort or case-controlled analytic studies.
2. **Evidence from multiple studies with or without the intervention being targeted, meta-analysis, opinions of respected authorities or expert panels, or information based on case reports.**
3. Uncontrolled experiments, descriptive studies, presenter's clinical experience/opinion or research in progress.

The majority of this presentation will be based on **Level 2** Evidence.

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SORRY

DOES NOT WORK

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SORRY w/

TRANSPARENCY
ACCOUNTABILITY
RESPONSIBILITY
PREVENTIVE ACTIONS

DOES WORK

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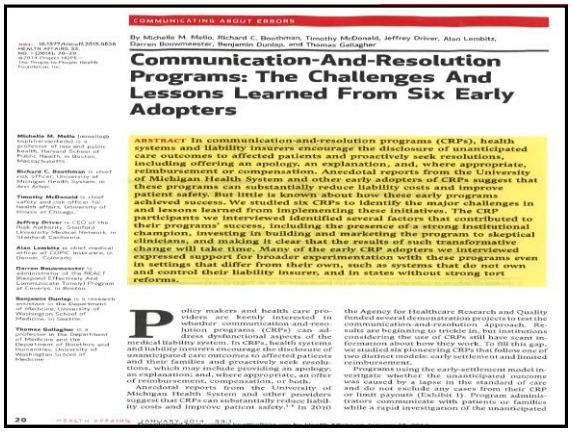

COMMUNICATING ABOUT ERRORS

By Michelle M. Mello, Richard C. Boothman, Timothy McDonald, Jeffrey Driver, Alan Lembitz, Darren Bournemester, Benjamin Dunlop, and Thomas Gallagher

Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters

ABSTRACT In communication-and-resolution programs (CRPs), health systems and liability insurers encourage the disclosure of unanticipated care outcomes to affected patients and proactively seek resolutions, including offering an apology, an explanation, and, where appropriate, reimbursement or compensation. Anecdotal reports from the University of Michigan Health System and other early adopters of CRPs suggest that these programs can substantially reduce liability costs and improve patient safety. But little is known about how these early programs achieved success. We studied six CRPs to identify the major challenges in and lessons learned from implementing these initiatives. The CRP participants we interviewed identified several factors that contributed to their programs' success, including the presence of a strong institutional champion, investing in building and marketing the program to skeptical clinicians, and making it clear that the results of such transformative change will take time. Many of the early CRP adopters we interviewed expressed support for broader experimentation with these programs even in settings that differ from their own, such as systems that do not own and control their liability insurer, and in states without strong tort reforms.

Policy makers and health care providers are keenly interested in whether communication-and-resolution programs (CRPs) can address dysfunctional aspects of the medical liability system. In CRPs, health systems and liability insurers encourage the disclosure of unanticipated care outcomes to affected patients and their families and proactively seek resolutions, which may include providing an apology, an explanation; and, where appropriate, an offer of reimbursement, compensation, or both.

Anecdotal reports from the University of Michigan Health System and other providers suggest that CRPs can substantially reduce liability costs and improve patient safety.[1] In 2010 the Agency for Healthcare Research and Quality funded several demonstration projects to test the communication-and-resolution approach. Results are beginning to trickle in, but institutions considering CRPs have little hard information about how they work. To fill this gap, we studied six pioneering CRPs that follow one of two distinct models: early settlement and limited reimbursement.

Programs using the early-settlement model investigate whether the unanticipated outcome was caused by a lapse in the standard of care and do not exclude any cases from their CRP or limit payouts (Exhibit 1). Program administrators communicate with patients or families while a rapid investigation of the unanticipated

3Rs program background

- COPIC's claim philosophy
  - Compensate only negligently injured patients
  - Minimize waste of resources in tort system
  - Defend defensible medicine regardless of cost

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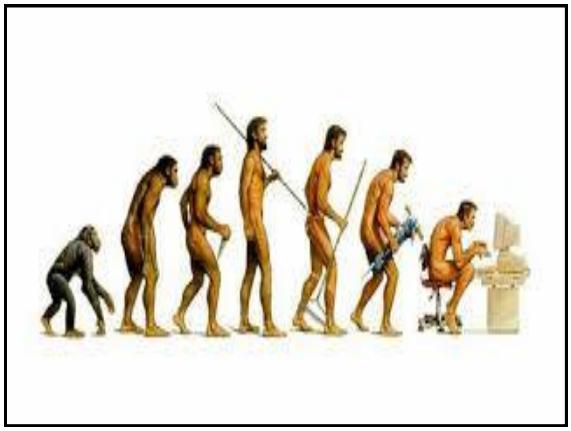
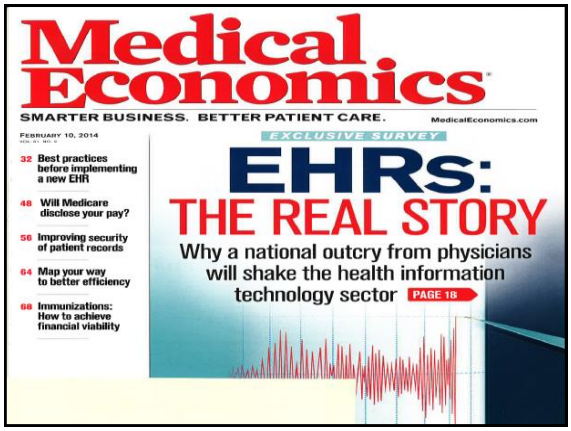
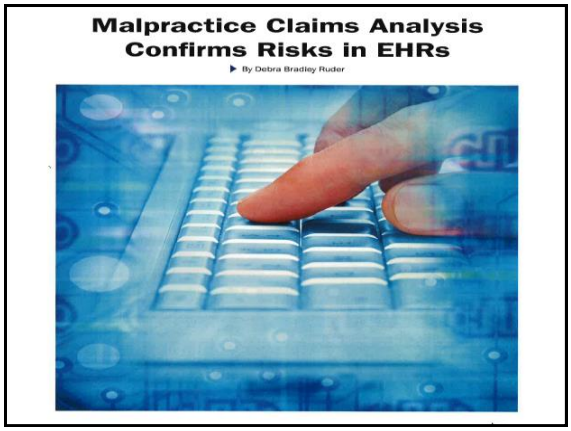
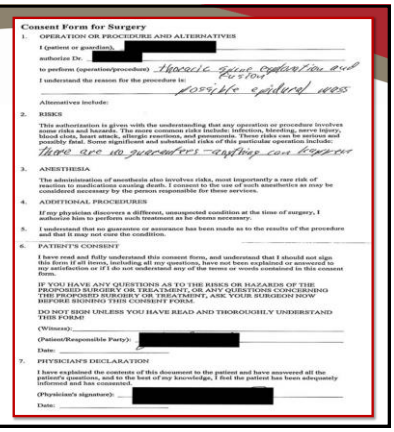






Consent for Spine Exploration and Fusion



Consent Form for Surgery

1. OPERATION OR PROCEDURE AND ALTERNATIVES

I (patient or guardian), [redacted]

authorize Dr. [redacted]

to perform (operation/procedure) thoracic spine exploration and fusion

I understand the reason for the procedure is: possible epidural mass

Alternatives include:

2. RISKS

This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, and pneumonia. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular operation include: there are no guarantees - anything can happen

3. ANESTHESIA

The administration of anesthesia also involves risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services.

4. ADDITIONAL PROCEDURES

If my physician discovers a different, unsuspected condition at the time of surgery, I authorize him to perform such treatment as he deems necessary.

5. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

6. PATIENT'S CONSENT

I have read and fully understand this consent form, and understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED SURGERY OR TREATMENT, OR ANY QUESTIONS CONCERNING ALTERNATIVE FORMS OF TREATMENT, ASK YOUR SURGEON NOW BEFORE SIGNING THIS CONSENT FORM.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM!

(Witness): _____

(Patient/Responsible Party): [redacted]

Date: _____

7. PHYSICIAN'S DECLARATION

I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

(Physician's signature): [redacted]

Date: _____

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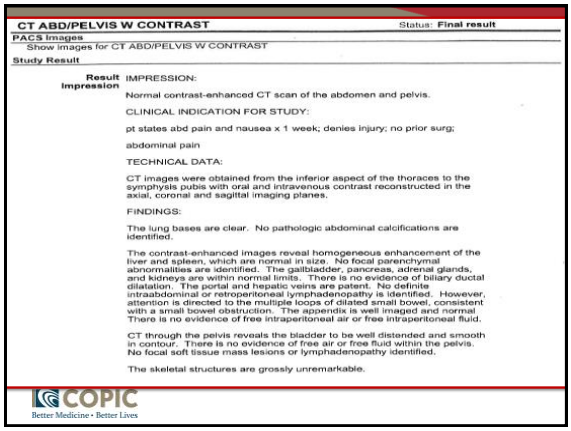

CT ABD/PELVIS W CONTRAST Status: **Final result**

PACS Images

Show images for CT ABD/PELVIS W CONTRAST

Study Result

Result Impression

IMPRESSION:

Normal contrast-enhanced CT scan of the abdomen and pelvis.

CLINICAL INDICATION FOR STUDY:

pt states abd pain and nausea x 1 week; denies injury; no prior surg;

abdominal pain

TECHNICAL DATA:

CT images were obtained from the inferior aspect of the thoraces to the symphysis pubis with oral and intravenous contrast reconstructed in the axial, coronal and sagittal imaging planes.

FINDINGS:

The lung bases are clear. No pathologic abdominal calcifications are identified.

The contrast-enhanced images reveal homogeneous enhancement of the liver and spleen, which are normal in size. No focal parenchymal abnormalities are identified. The gallbladder, pancreas, adrenal glands, and kidneys are within normal limits. There is no evidence of biliary ductal dilatation. The portal and hepatic veins are patent. No definite intraabdominal or retroperitoneal lymphadenopathy is identified. However, attention is directed to the multiple loops of dilated small bowel, consistent with a small bowel obstruction. The appendix is well imaged and normal. There is no evidence of free intraperitoneal air or free intraperitoneal fluid.

CT through the pelvis reveals the bladder to be well distended and smooth in contour. There is no evidence of free air or free fluid within the pelvis. No focal soft tissue mass lesions or lymphadenopathy identified.

The skeletal structures are grossly unremarkable.

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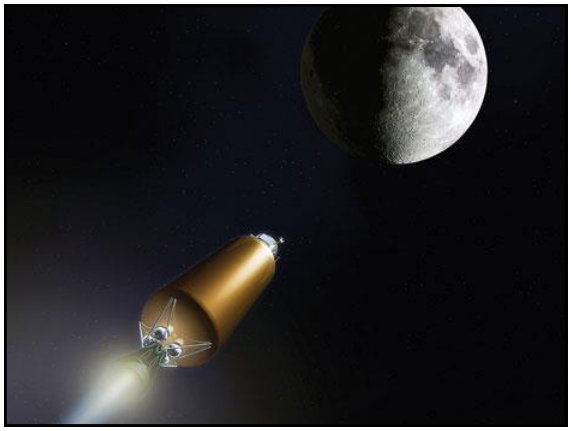

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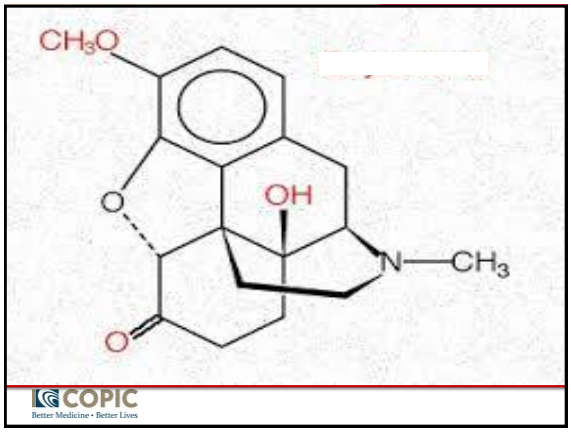

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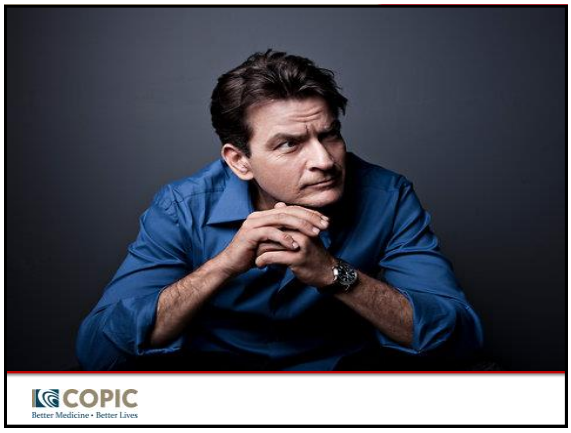

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SUMMARY

1 Sorry plus accountability- 7 Pillars
2 EHR's and safety/risk
3 Informed Consent
4 Physician Burnout and Ways to combat- resiliency
5 Radiologist/Clinician communication
6 Systems
7 PAs and APNs
8 Opioids
9 Noncompliant and AMA patients
10 Where the cash is drives where the risk is- STROKE

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Thank you

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Patient Safety and Risk Management
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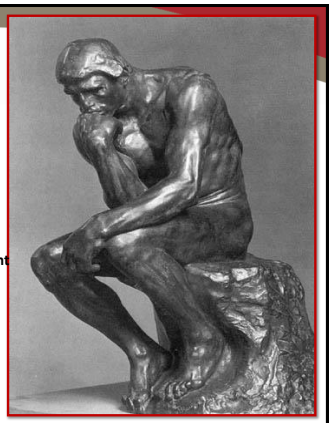

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