The Role of Risk Management in Patient Safety

Frank Federico
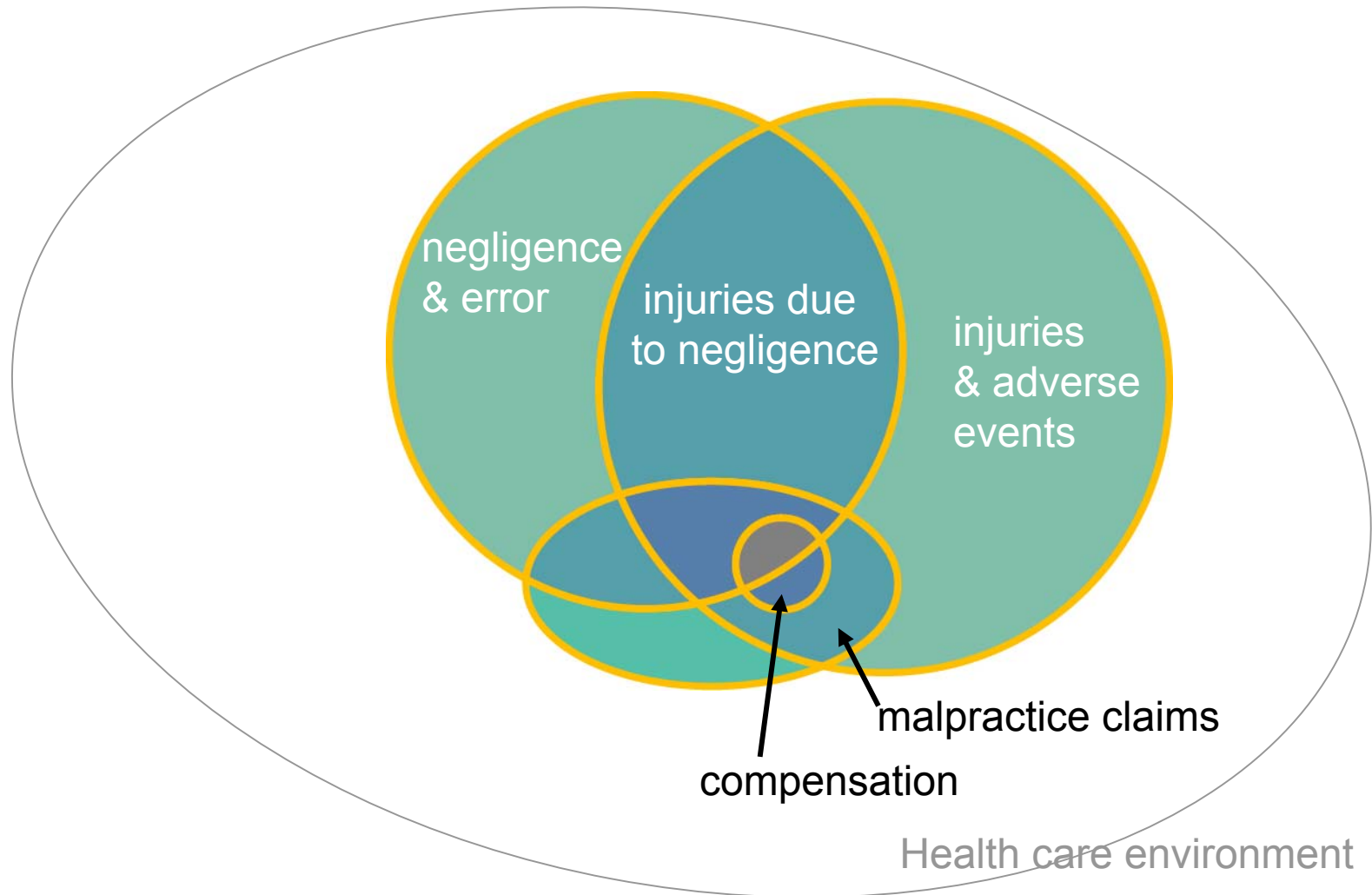
Loss Prevention/Patient Safety Specialist

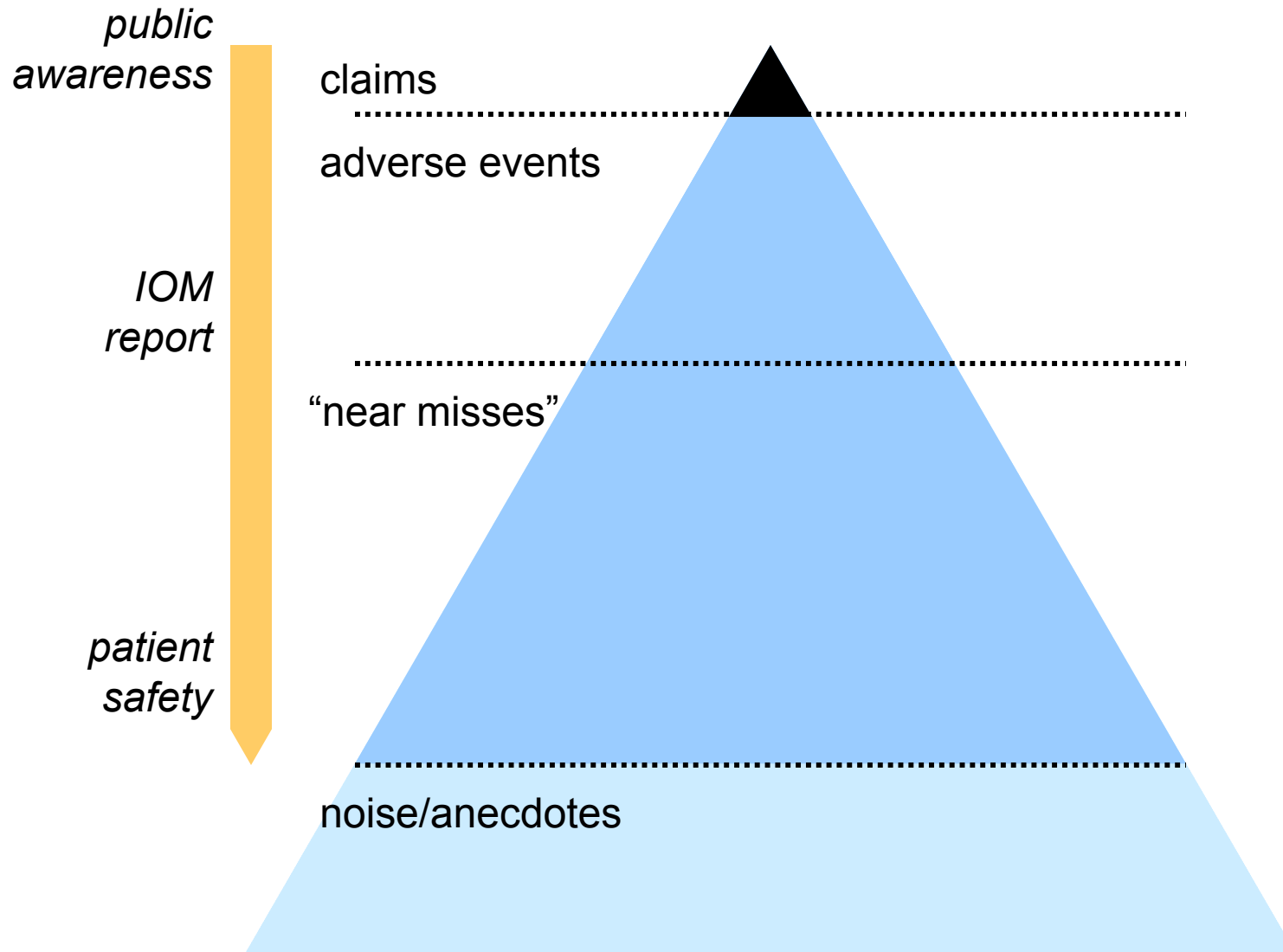**Risk Management Foundation**

Harvard Affiliated Institutions

Cambridge, MA

RMF

Medical Injuries, Mistakes, and Malpractice Claims

negligence & error

injuries due to negligence

injuries & adverse events

malpractice claims

compensation

Health care environment

RMF: *Claims are the TIP of the iceberg!*

public
awareness

claims

adverse events

IOM
report

"near misses"

patient
safety

noise/anecdotes

RMF

Traditional Risk Management Functions

- **Loss control**
- **Point person for claims and potential claims**
- **Claims analysis**
- **Risk avoidance**
  - **Identification, evaluation and treatment of financial loss**
- **Identify areas of potential risk**
  - **Incident reports**
- **Education**
- **Resource Materials**
- **Guidelines**

Traditional Risk Management Functions

- **Links to underwriting**

- **Interface with insurance company and regulators**

- **May or may not be linked to QA**

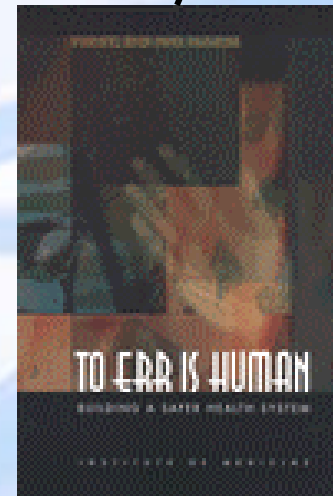- **May be linked to General Counsel**

RMF

The Patient Safety "Explosion"

1990

1999

Narrow range of projects:
Focus on legal risk management/loss prevention

Focus on
Patient Safety

TO ERR IS HUMAN

Risk Management in Patient Safety

- **Change the culture from reactive to interactive risk management**

- **Provide leadership in the area of safety**

- **Align the risk management process around organization key strategic imperatives**

- **Link risk data to financial data**

- **Link JCAHO standards to risk management plan**

Youngberg,B, Meeting the Challenges of Patient Safety through the design of a New Risk Management Process, ASHRM Journal Fall 2001

Risk Management in Patient Safety

**Manage risk –** *reactive, interactive*

- **Mitigate risk from unexpected occurrence – to patient, to provider**

- **Investigate and defend claims – efficiently and effectively**

- **Prevent future errors and losses – drive performance improvement, education, and practice evaluations from data and learning**

- **Evaluate and underwrite risk exposures – insurance and retention**

Risk Management in Patient Safety

Understand risk – *vulnerabilities, exposures*

- **Code cases that lead to clinical investigation, to claim, to payment**
- **Code and incorporate events and non-standard data**
- **Compare data and evaluate hypotheses**
- **Identify areas of excellence, of opportunity, of distinction**

Claims by Risk Management Issues

Risk Management Foundation, Cambridge, MA
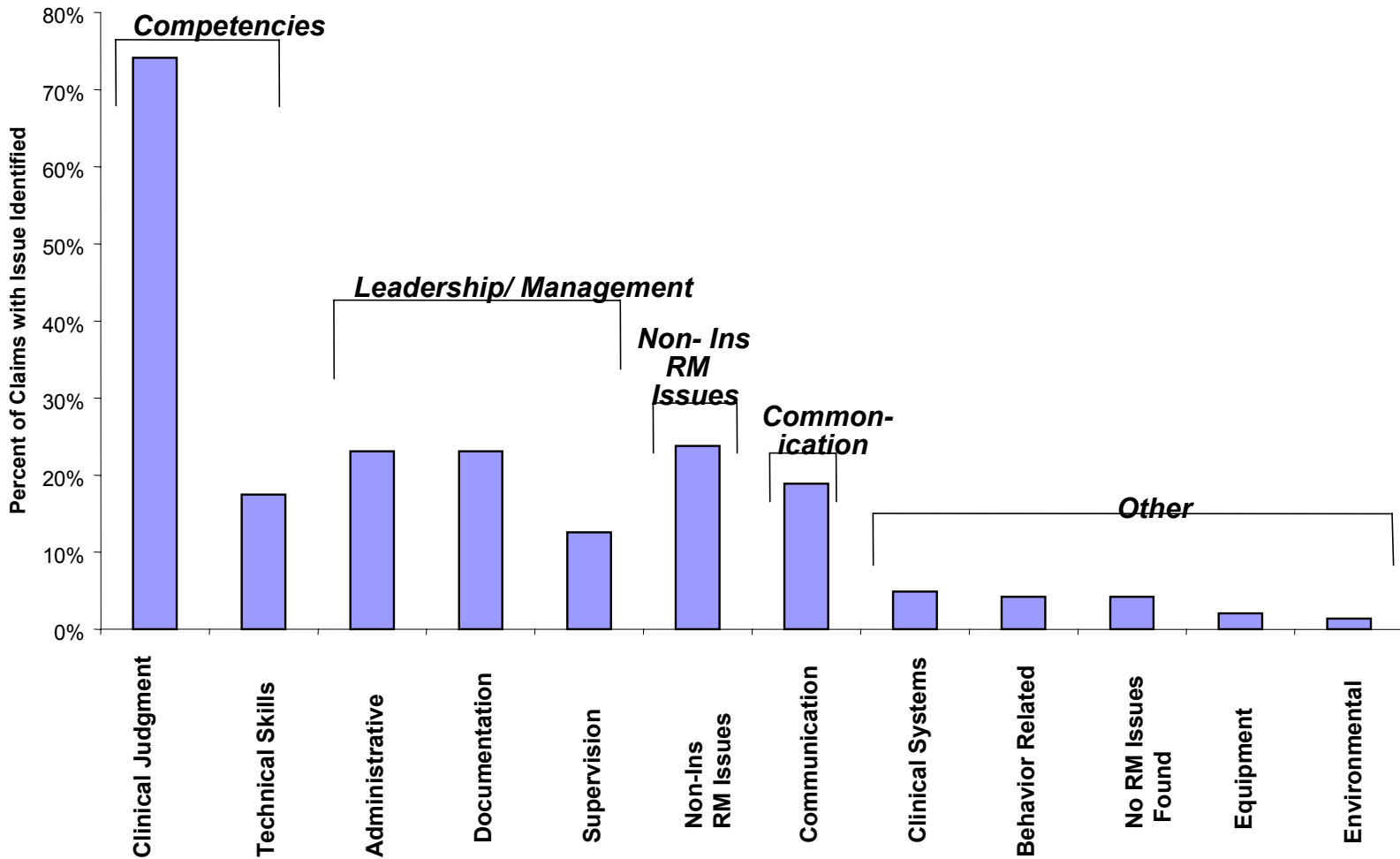
Risk Management in Patient Safety

Integrate risk and clinical programs – *engage in improvements*

- **Communicate and engage executives and clinical leadership**

- **Incorporate insights from QA, care, medical management**

- **Coordinate improvement activities – everyone reacts to the same data**

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Risk Management in Patient Safety

- **Medication errors and harm**
- **Readmissions**
- **Infection rates**
- **Unplanned extubations and re-intubations**
- **Data from high risk areas: OB, ED, Surgery, Radiology**
- **Deaths**

Link to Financial Data
Costs of Adverse Events

- **Cost of ongoing care**
- **Lost productivity for patient**
- **"Second Victim"**
- **Medical malpractice case**
  - **Indemnity payments**
  - **Defense costs**
- **Premium adjustments**
- **Defensive medicine**
- **Reputation**
- **Market share**

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Risk management – *closing the loop with data*

Standards of care

Learning

Vulnerabilities

Issues

Defensibility

Loss prevention

Unexpected occurrence or outcome

Risk mitigation

Assertion of claim or lawsuit

Claims management and Defense

Process improvement

Education

Investigation

Regulatory compliance

Medical management (peer review)
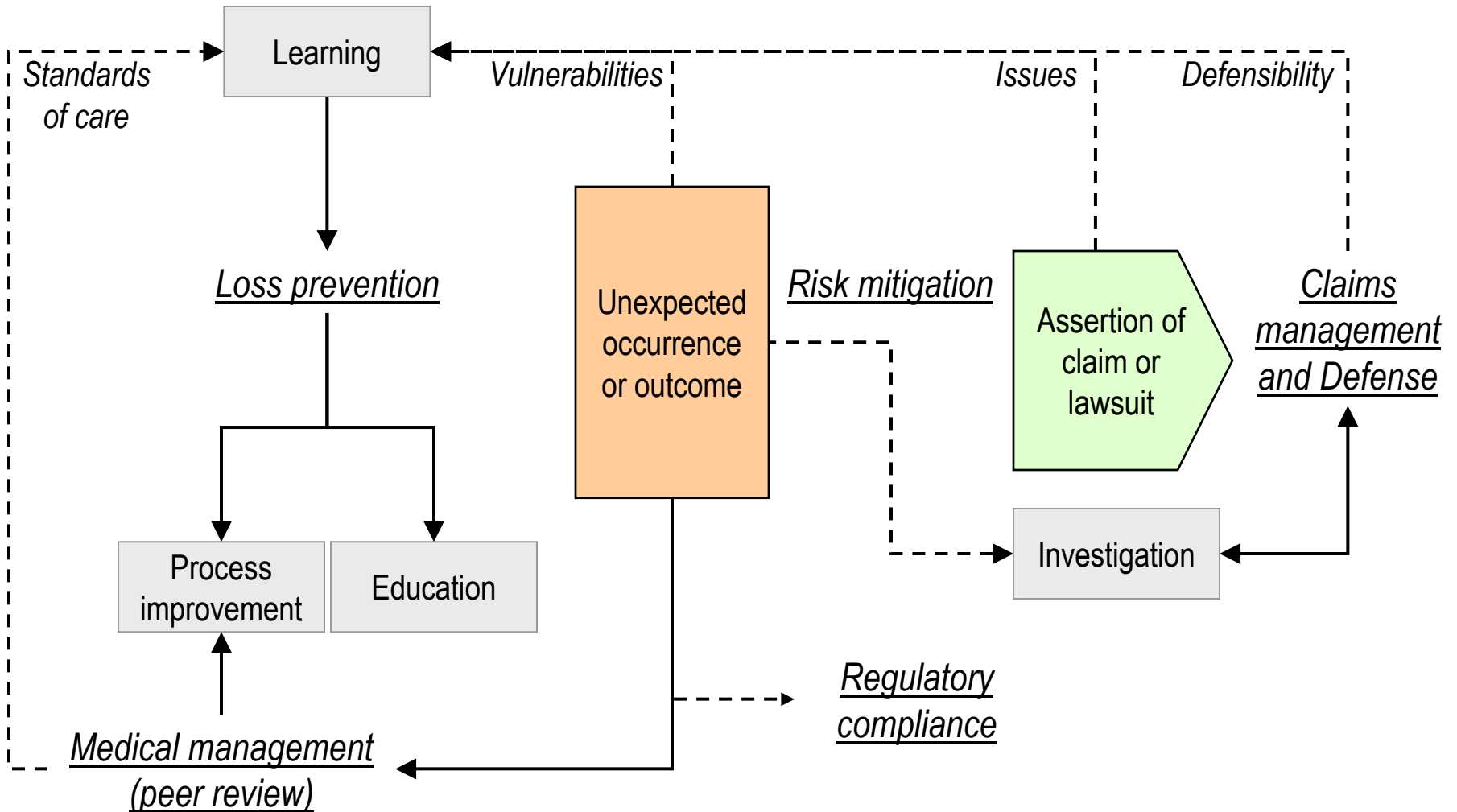
Patient Safety Explosion: The RMF Perspective

1999
Catalysts &
First Steps

2000
Digging Deeper

2001
Revving Up

2002
Take Off

- IOM Report
- RMF develop.
  Patient Safety
  Mission
- BrCa Algo

- **Patient Safety Advisory Group formed**

- **Target Areas**
  drill down,
  focused analysis

- **Core Curriculum** development
- **Human Factors Integration**
  - symposium
    - surgery observation
    - L&D training
- **HSRI formed**
- Reporting systems

- **Human Factors** dx & anti-coag projects

- **Reporting** systems

MIMEPS Project

| CRICO Bd approve pt safety mission | CRICO Bd target area grants ($50K) | CRICO Bd pt safety grants ($500K) | CRICO Bd update on key inits |

Current Initiatives

- **Diagnosis**
  - **Breast Care Algorithm update**
  - **Colo-Rectal Screening model (HF)**
  - **"Missed MI" study**
- **Surgery**
  - **Human Factors Observation study at BWH**

Current Initiatives

- **Obstetrics**
  - **OB Team Training at BIDMC**
  - **OB Guidelines**
  - **Incentive Rating Plan pilot**
- **Medication**

  Results of two CRICO-funded studies –
  - **Ambulatory Oncology Study**
  - **Analysis of Medication-Related Malpractice Claims** (Archives of Internal Medicine, Nov 2002)
  - **Improving Medication Prescribing** (NEJM April 15, 2003)

Disclosure of Unanticipated Outcomes

- **Component of a safe culture**
- **Patients want to know**
- **Risk managers: a hindrance or a support?**
- **May impact litigation**

Pitfalls

- **More data collection= more disclosure?**
- **Increase in suits in the short run**
- **Definition of medical error not clear**
- **Error does not always lead to harm[1]**
- **Error does not mean negligence**

1. Bates DW, et al. Incidence of Adverse Drug Events and Potential Adverse Drug Events: implications for prevention. JAMA, 1995; 274(1): 29-34

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