

 **Curi**
A MEDICAL MUTUAL CO.

Identifying Unexpected and Practice-Saving Clinical Risk Exposures: A Case Study

October 29, 2019

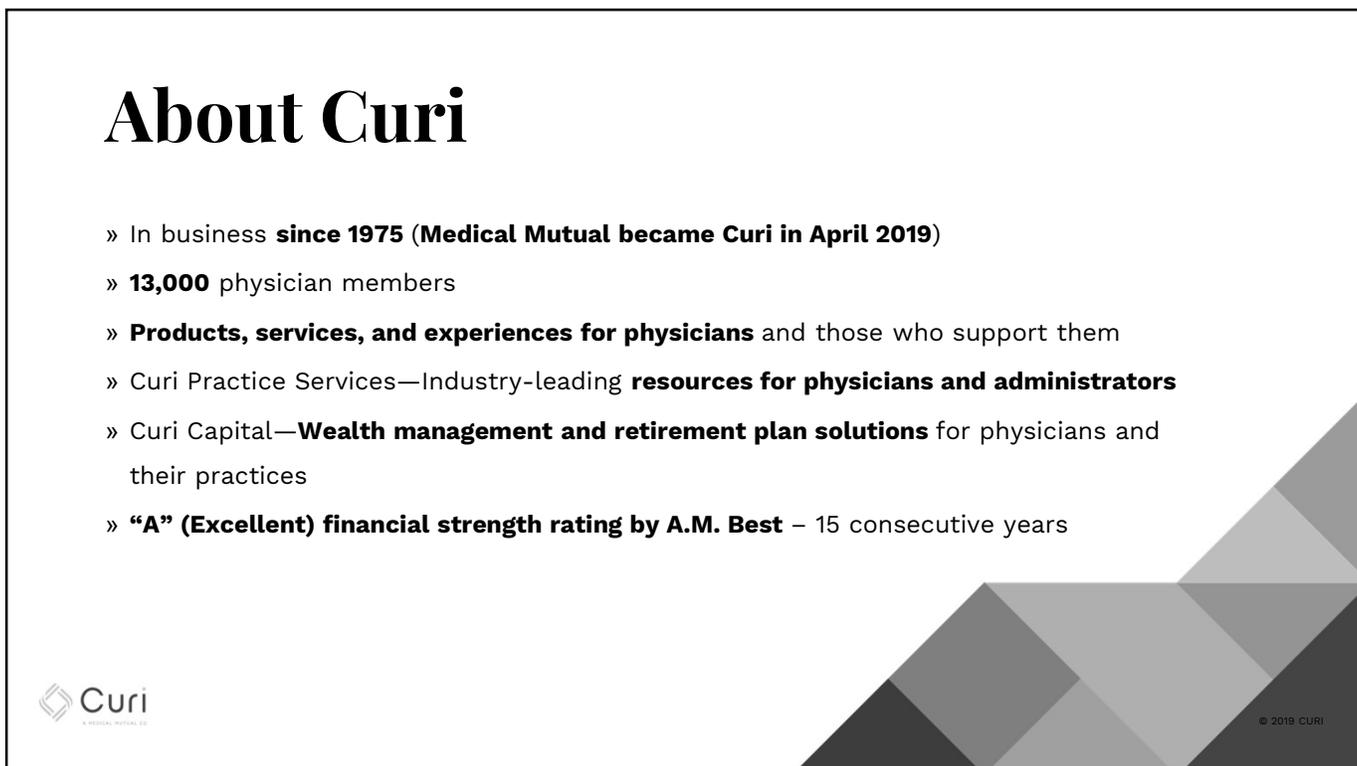
Donna Nicholson, MBA, BSN, CPCO

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1

About Curi

- » In business **since 1975 (Medical Mutual became Curi in April 2019)**
- » **13,000** physician members
- » **Products, services, and experiences for physicians** and those who support them
- » Curi Practice Services—Industry-leading **resources for physicians and administrators**
- » Curi Capital—**Wealth management and retirement plan solutions** for physicians and their practices
- » **“A” (Excellent) financial strength rating by A.M. Best** – 15 consecutive years



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2



KEY CONCEPTS

Considerations for Your Practice

- » Compliance and risk issues are intertwined
- » Patient safety should be the focus
- » People are your biggest assets and your biggest risks
- » The four E's—educate, engage, evaluate, educate



What is the last large verdict
you can recall?

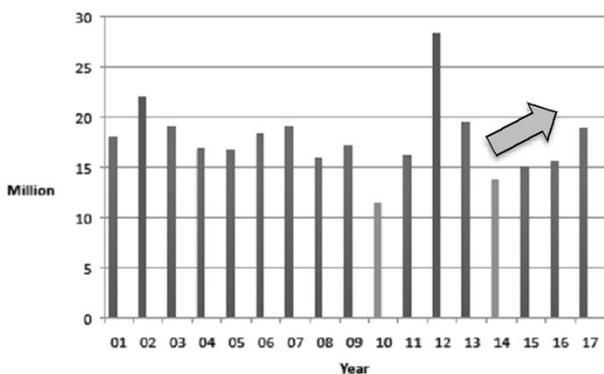
When did it occur?



7

MALPRACTICE & BROAD REGULATORY TRENDS

Claims Trends



Average of **Top 50 Med-Mal Verdicts, 2001-17**

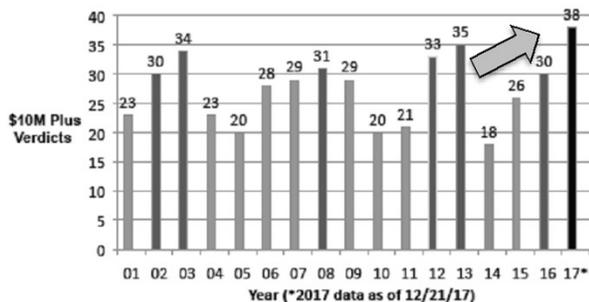


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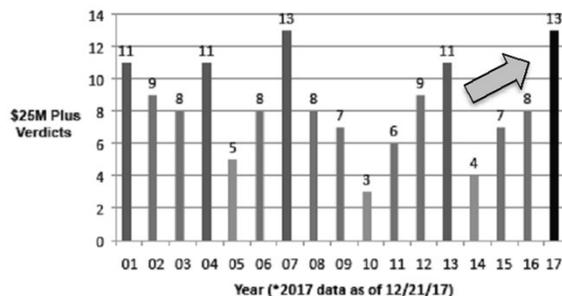
MALPRACTICE & BROAD REGULATORY TRENDS

Claims Trends

\$10M+ Verdicts, 2001-17



\$25M+ Verdicts, 2001-17



MALPRACTICE & BROAD REGULATORY TRENDS

MPL Market Trends

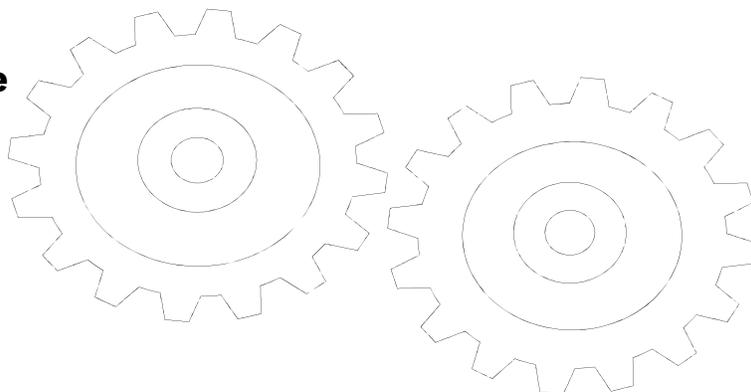
- » **Combined ratio** is now 107% (versus 96%→97%→102%→102%—prior 4 years)
- » **Defense costs** up 60% since 2008 (10 yrs.)
- » **Litigation financing** companies (even PE firms) involvement way up
- » **Severity** up dramatically; \$10M+ verdicts up US-wide 116% from 5 yrs. ago: \$1M claims doubled in 10 yrs.
- » **Rate increases** by carriers b/w 3% & 12%
- » **Reinsurance** market hardening



THE CASE

The Intersection of Compliance and Risk Mitigation

Compliance



Risk Mitigation



POLLING QUESTION

Does your practice have an established, robust compliance program?

- » Yes
- » No



POLLING QUESTION

Does your practice have an established peer review program?

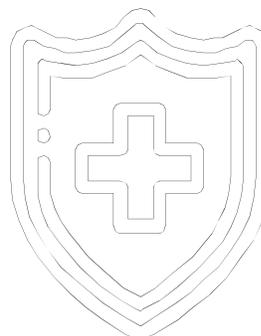
- » Yes
- » No



THE CASE

What We Do

- » Risk Assessments—on-site and virtual
- » Interviews
- » Medical Record Audits
- » Results
- » Action Plans
- » Reassessments



THE CASE

Our Process

- » Each year, Curi conducts a gap analysis and needs assessment based on results from previous years' risk assessments and claims.
- » There's a greater risk of adverse outcomes if operational processes are inconsistent or non-existent.



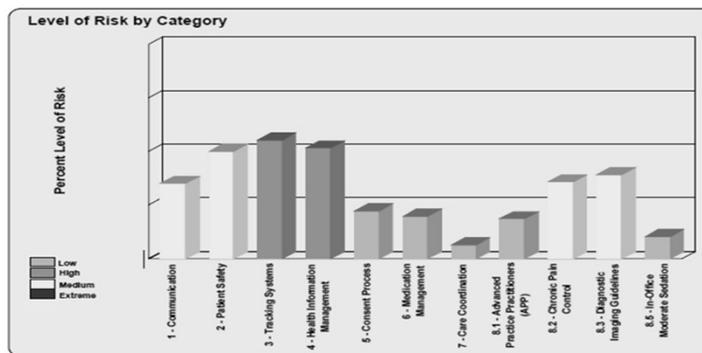
THE CASE

Risk Assessment Stats

Locations	Staff Interviews	Providers	Medical Records Reviews	Potential CMEs	Risk Consultant Hours
34	19	209	627	5-20 Credits*	843.5

THE CASE

Aggregate Results—All Locations



THE CASE

Top Risk Categories—All Locations

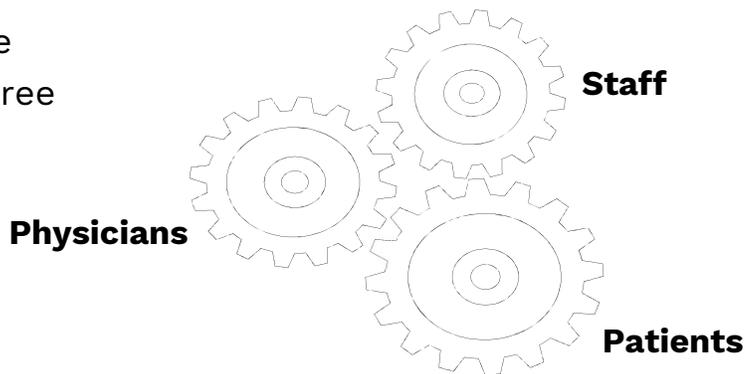
- » **Communication**—Documenting provider interactions and after-hours calls; using triage protocols
- » **Patient Safety**—Staff competency
- » **Tracking**—Appointments, diagnostic tests, and high-risk referrals
- » **Health Information Management**—Documentation standards/incomplete notes and texting issues
- » **Pain Management**—Failed controlled drug policies
- » **Diagnostic Imaging**—Written protocols, tracking final reads, and over-read and misread processes



THE CASE

Key Findings—Communication

Good communication in the practice setting involves three key audiences.



THE CASE

Key Findings—Communication

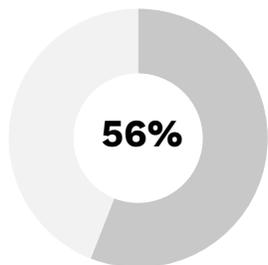
- » Poor communication continues to be one of the top reasons we see claims.
- » Research also shows many patients with a bad outcome decide to sue their physician **not** due to a lapse in quality of care or medical negligence, but in how the physician communicated with the patient.

30%

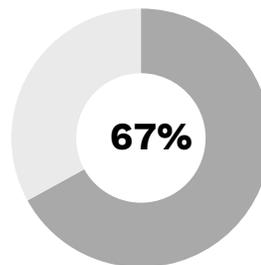
malpractice complaints involved communication failure*

THE CASE

Key Findings—Communication



Majority of practices involved had **medium-to-extreme risk**



Communication top risk at 67%



THE CASE

Key Findings—Communication

» Absence of documentation consulting the provider regarding advice to patients

- Patient calls: Leg was swollen, red, and painful. He was diagnosed with a blood clot and prescribed Voltaren; wanted to ask physician if it ok to take this medication so soon after his surgery, which was two days ago; no documentation that provider answered question or patient was notified.
- Patient calls: Hand swollen following physical therapy and wants to know if normal; call assigned to physician and staff; staff indicates “called patient and advised.” No documentation to support advice received from provider or what the patient was advised to do.



THE CASE

Key Findings—Communication

- » Absence of consistent written triage protocols
- » Scope-of-practice concerns
- » After-hours calls not consistently documented
- » Online communication, text messages, and faxed information not placed in medical record

THE CASE

Key Findings—Patient Safety

- » New staff members and clinical competencies not documented
- » Concern that staff practicing beyond their scope of practice
 - Staff offering clinical advice over the phone absent of documentation that provider was consulted
 - Staff refilling medications without documentation of protocols or provider approval
 - Staff e-cribing controlled substances using providers login credentials

THE CASE

Key Findings—Tracking Systems

» No written process for tracking missed appointments, referrals or diagnostics

- Referral made to pediatric orthopedic specialist at teaching hospital for 10-year-old with sternoclavicular joint swelling and tenderness; parent called back 4 days later, because consultant refused referral as staff mistakenly put reason as chest pain; changed diagnosis to clavicle pain, but no further documentation or follow-up noted in chart. Treatment delayed.
- Return visit—no discussion with patient regarding chest x-ray ordered several weeks prior but never obtained.



THE CASE

Key Findings—Health Information Management

» Incomplete documentation—evidence of templating and copying and pasting from one note to another

- Chief complaint—Hand Problem. Performed left knee injection—did not document procedure note or perform an assessment. No documentation regarding the chief complaint of a hand problem.
- Follow-up visit—Provider documented “unable to take steroids or have injections with steroids in future as these cause significant problem.” Allergy list not updated to indicate this alert.
- Office visit—History of present illness documented: “He has been having pain in his low back area, radiating down both legs with numbness and tingling in the bottom of his feet. He is having tightness in the hips along with groin pain.” Review of systems: “No joint stiffness, arthralgia/joint pain, back pain, swelling in the extremities, joint stiffness, numbness/tingling.”



THE CASE

Key Findings—Health Information Management

- » Sharing of user names and passwords very prevalent
- » Staff use provider's log-in credentials to e-scribe controlled substances



27

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27

THE CASE

Key Findings—Pain Management

- » Inconsistent documentation of accessing the prescription drug monitoring program (PDMD)
 - 3/13—Oxycodone-acetaminophen ordered, **no PDMP check documented**, ordered 15 days of medication; did not address alert to avoid use with diazepam; 3/20—Refilled for another 15 days, no document PDMP check and still did not address alert.
 - Provided multiple refills, **no documented PDMP checks**; 5/29—patient post-op visit with complaints of pain, ordered Oxycodone-acetaminophen, **no documentation of review of PDMP**, ordered for 11 days.
 - 4/23—Rehab medicine visit, refill Oxycodone 10/325 for a 30-day supply, **no check of state PDMP**. Refilled every month since 2016; last PDMP check documented on 7/24 the year before.
 - 12/21-1/25—Prescribed oxycodone, methadone 5 mg and methadone 10 mg at the same time for a 93 year old man, without addressing alerts.



28

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28

THE CASE

Key Findings—Pain Management

» Inconsistent documentation of pain level, assessment of recreational drugs, follow-up of prior recommendations

- New patient visit—No assessment of recreational drug use, past medical history includes chronic back pain and is currently prescribed Hydrocodone from pain management physician.
- Refills completed—Did not document pain level; referred to pain clinic on 3/13 but did not document discussion with pain clinic and continued to refill pain medications.
- Provider prescribed Norco for knee pain—Previous note from physician was not to prescribe any controlled pain medication due to violation in pain contract.
- Urine drug screen—Result documented as positive for cannabinoids, "will send to confirm;" next visit not addressed with patient nor confirmed with verified result.



THE CASE

Key Findings—Diagnostic Imaging

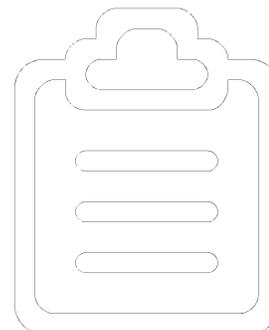
- » Written protocols seem incomplete regarding tracking final reads and over-reads as well as provider and patient notification for misreads.
- » Peer review process related to over-reads was not clear.



THE CASE

What We Did

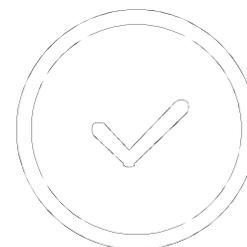
- » Summarized and communicated our findings to the practice
- » Documented all findings in a standard report
- » Encouraged practice/learners to review findings, identify desired changes, and implement



THE CASE

Our Recommended Takeaways

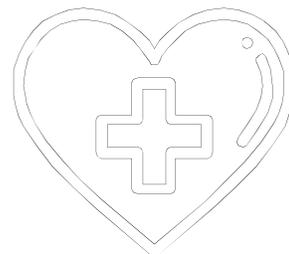
- » Document action and improvement plan
 - Secure buy-in from leadership
 - Train providers and staff on new policies and protocols
 - Hold people accountable
 - Reassess success and make changes as needed
 - Repeat
- » Training, consistency, accountability across all locations
- » The four E's—educate, engage, evaluate, educate



THE CASE

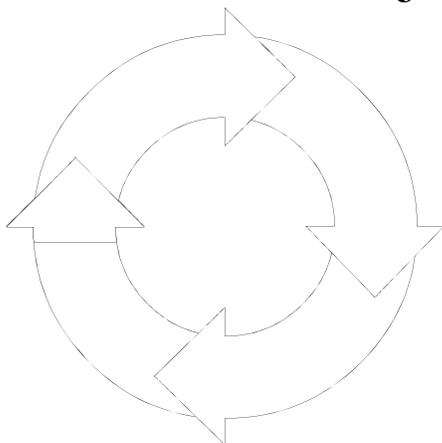
Our Next Steps

- » On-site assessments as the exception rather than the rule
- » Implementation of a remote process using an online risk assessment tool
- » A self-sufficient process (without sacrificing our data/results)



THE CASE

Plan. Do. Study. Act.



-  **Plan** Strategy
-  **Develop** & Test Strategy
-  **Monitor** Strategy
-  **Reassess** & Respond

THE CASE

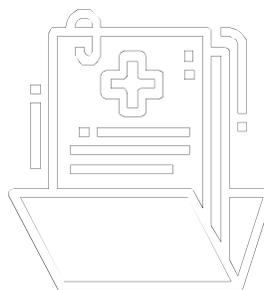
Revisiting Your Compliance Audit & Monitoring Program

- » Do you include an assessment of potential clinical risk?
- » Do your documentation audits include an assessment for test tracking, communication documentation, confirmation for compliance with controlled drug monitoring programs?
- » Does your compliance training program expand to include compliance with clinical treatment protocols?
- » Is staff competency and scope of practice considered in your compliance program?

THE CASE

Medical Record Assessment Tool

- » Clinical Documentation
- » Communications
- » Health Information Management
- » Consents
- » Privacy and Security
- » Quality Performance



Who are the plaintiffs?

37

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37

KEY CONCEPT REVISITED

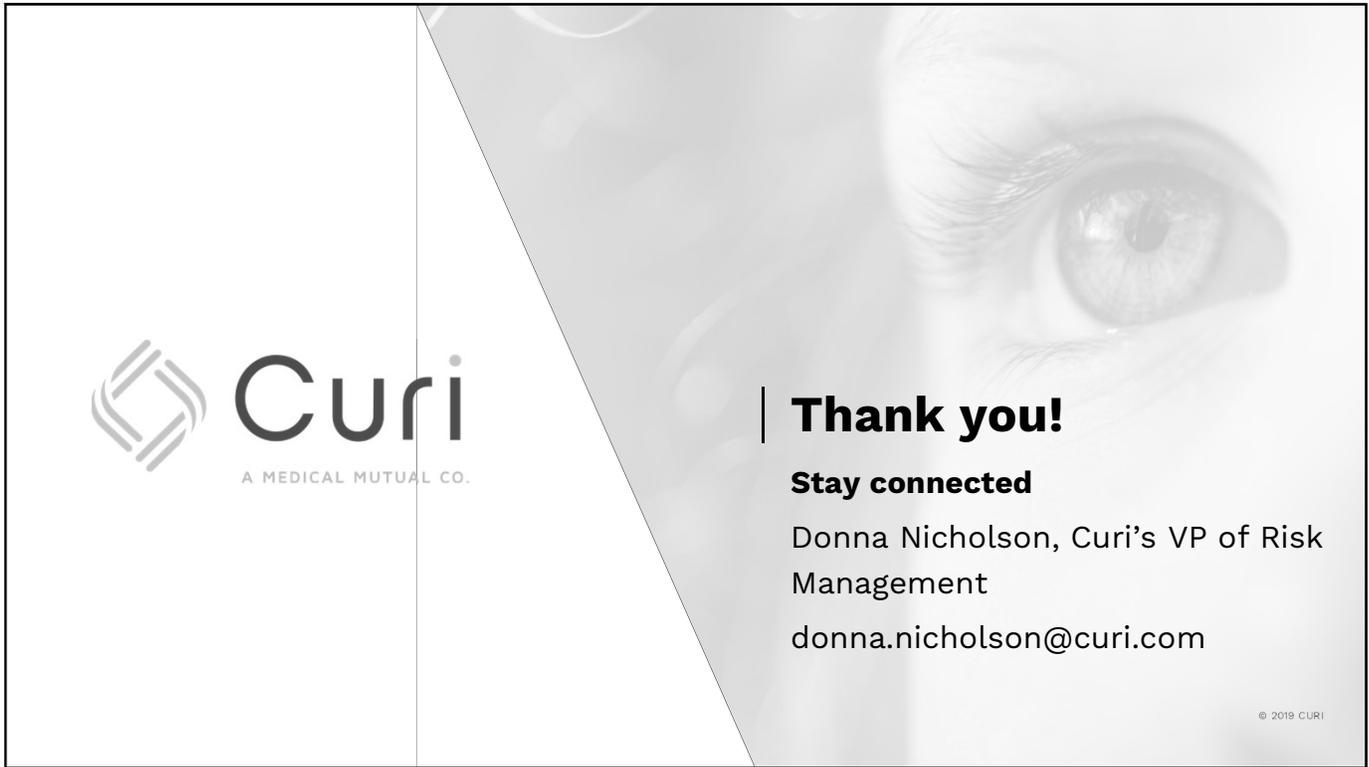
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38

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38



The image is a rectangular graphic divided into two main sections. The left section is white and contains the Curi logo, which consists of a stylized geometric icon of four interlocking lines forming a square, followed by the word "Curi" in a large, bold, sans-serif font. Below "Curi" is the text "A MEDICAL MUTUAL CO." in a smaller, all-caps, sans-serif font. The right section is a grayscale photograph of a woman's eye, looking directly at the camera. The eye is the central focus of this section. A vertical line separates the white section from the photograph section.

Thank you!

Stay connected

Donna Nicholson, Curi's VP of Risk Management

donna.nicholson@curi.com

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