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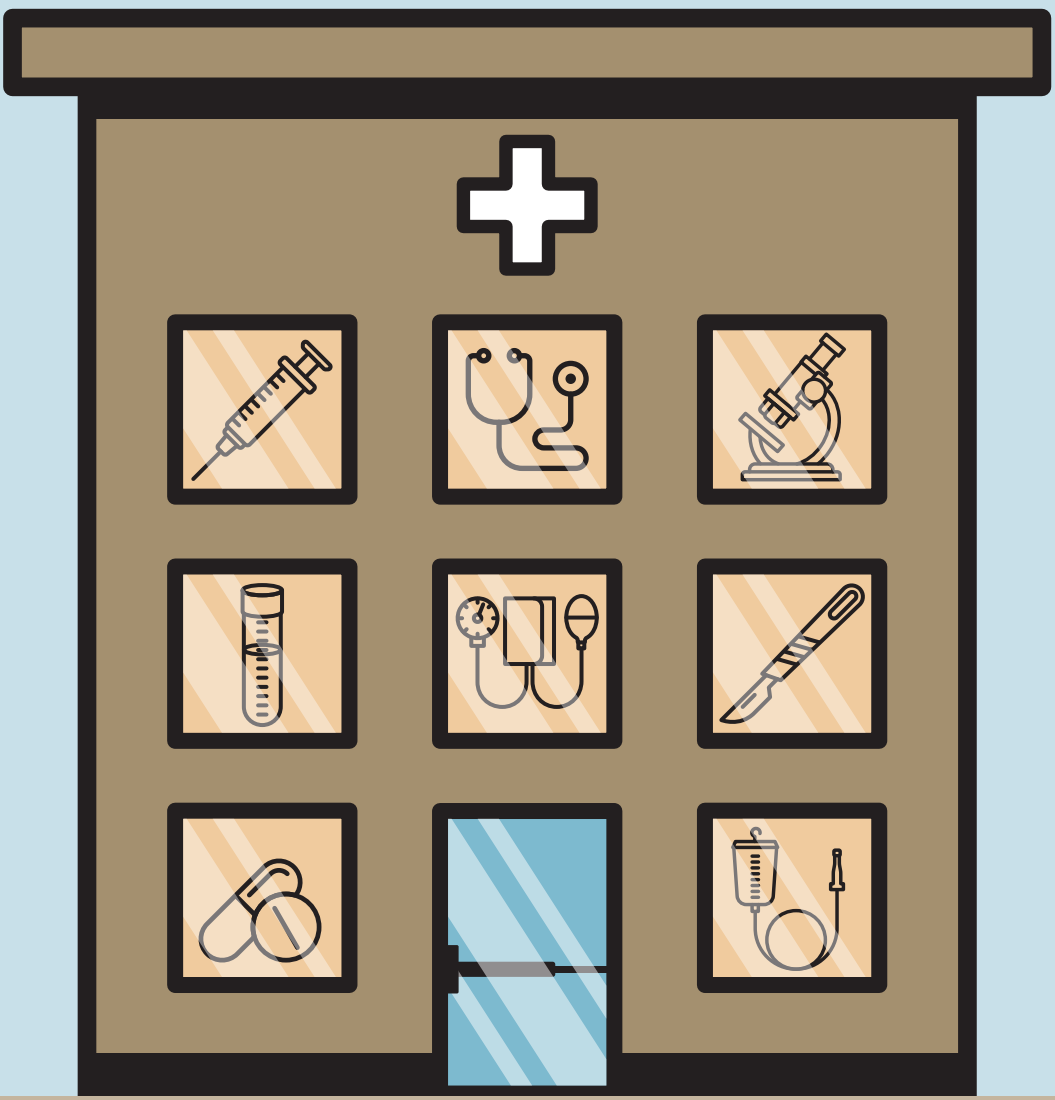
Common Factors®

Let's Get Clinical:
What Drives Risk in Clinics?



CONTENTS

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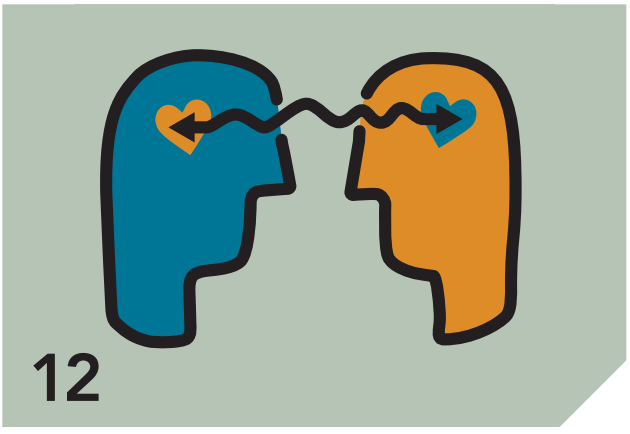

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Claims in the Clinic

A Look at the Data on the Top Risk Drivers in Outpatient Clinics

By Lori Atkinson, RN, BSN, CPHRM, CPPS and Liz Lacey-Gotz

What drives risk in the clinic setting? To answer this crucial question, Constellation examined data drawn from years of medical professional liability (MPL) insurance claims from its member clinics. Four top drivers of risk in clinics rose to the top: the diagnostic process, medical treatment, medication administration and surgical procedures.

Clinic risks aren't always based on the level of clinical knowledge or the technique of clinicians; for example, many adverse events occur because of breakdowns in diagnostic tracking and follow-up systems. As a subset of all health care settings, including hospital and ambulatory care settings, clinics tend to have fewer staff and are likely to have fewer RNs with the clinical experience required for telephone triage, or the expertise and systems training needed to aid in assessment and monitoring after procedures. Clinics also often have less advanced resuscitative training and equipment to deal with emergencies that may occur. And clinics often lack risk and patient safety staff and programs, which can limit progress toward better procedures and systems to mitigate risk.

Staying abreast of the key risk factors identified by the data enables clinics to make the changes needed to mitigate those risks, fill gaps in expertise and improve processes. Decision support tools, for example, can help clinicians limit diagnostic error, and better systems can aid clinicians in monitoring test results and coordinating follow-up care. Clinics may also determine a need for more training for care teams or more education for patients. These are all worthwhile efforts to support clinicians, limit liability and improve care for patients.

In the Clinic

Medical treatment errors are
#1 in OCCURENCE

Diagnostic errors are
#1 in COST

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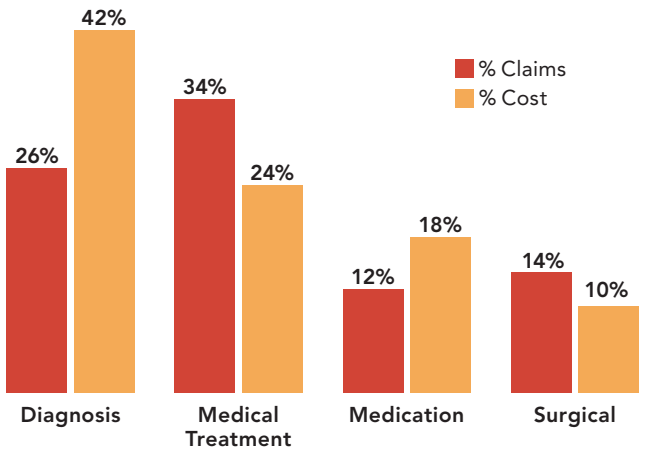
Top Allegations in Clinic Settings

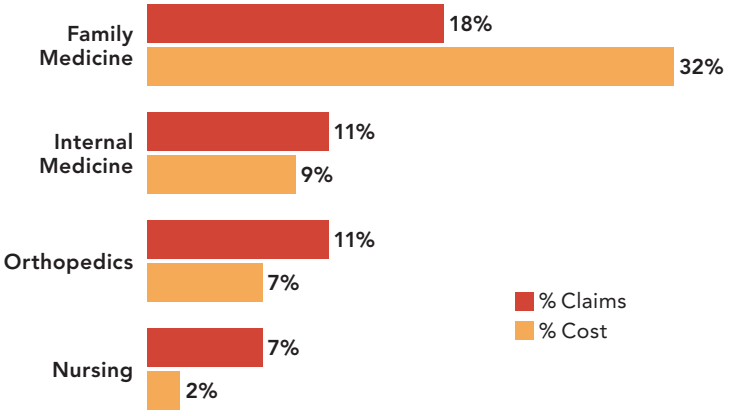
Diagnostic (Dx) error claims are the most expensive claims for clinics, contributing to almost half of costs (42%). This is largely due to the severity of harm caused by missed or delayed diagnosis. Medical treatment allegations are the second-most expensive (24%), even though they represent the largest percentage of all clinic claims (34%).



Constellation MPL claims reviewed 12/31/21

Top Responsible Care Teams in Clinic Claims

Nearly one-third of costs are driven by claims against family medicine physician care teams. They also account for the largest percentage (18%) of clinic claims.



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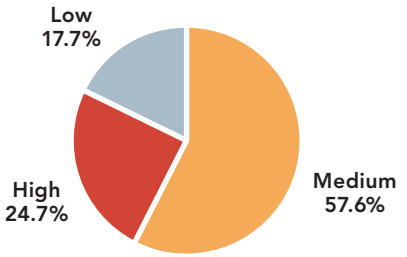
Severity of Harm in Clinic Claims

More than half of clinic claims are of medium severity, and about one-quarter are of high severity. Medium-severity claims can include temporary or permanent injury such as infections, missed fractures or retained surgical objects. High-severity claims include major or grave permanent injury such as blindness, paralysis, quadriplegia or death.



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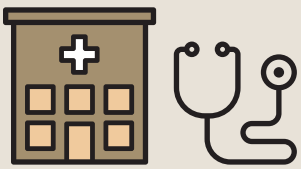


Top Risk Driver in Clinics—Diagnostic error allegations

In the clinic setting, Dx errors are the most expensive allegation, accounting for 42% of costs and 26% of claims. In general, Dx errors are more likely to originate in the clinic setting than in a hospital, because the clinic is most often where patients arrive with initial symptoms or for routine checkups. If testing is needed, the clinic may need to refer the patient to another facility or specialist to have those tests performed. Such referrals require follow-up and coordination of care, as well as appropriate timing and patient compliance. The complexity involved, and the multiple steps needed, can lead to gaps in care that drive Dx errors.

In the Clinic

Diagnostic Errors are

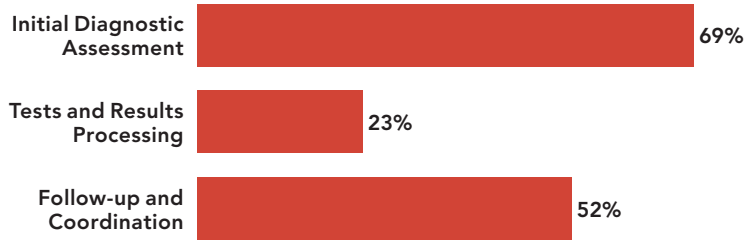
#1 in COSTS **#2 in OCCURRENCE**

Over half (69%) of clinic Dx error claims begin with issues that arise during the initial patient assessment: assessing and evaluating symptoms, establishing a differential diagnosis list, and ordering diagnostic tests to rule in or out potential diagnoses.

In many clinic cases (23%), tests and results processing is also an issue. Tests may be mislabeled or mishandled, findings may be inaccurate, or the ordering physician may fail to review the results in a timely manner, to name just a few possibilities.

Problems with follow-up and coordination occur in almost half of these claims (52%). Because follow-up care and care coordination are primarily delegated to other members of the care team, an accurate and timely diagnosis depends as much on the team and the clinic's systems as it does on the diagnosticians themselves. Establishing formal communication, improving processes and helping patients stay engaged can help improve the diagnostic process and limit errors.

Dx Error Top Contributing Factors



A claim may have, and often does have, multiple breakdowns in the diagnostic care process that result in the missed or delayed diagnosis.

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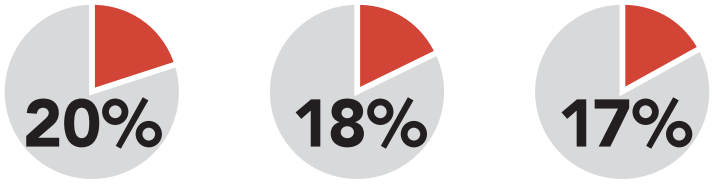
Top Three Missed Diagnoses in the Clinic



Cancers
Breast, Lung, Skin

Vascular events
Stroke, Heart attack, Venous thromboembolism

Infections
Appendicitis, Meningitis, Sepsis

Constellation MPL claims reviewed 12/31/21

When a cancer diagnosis is missed:

49% of cases involve a delay or failure to order a diagnostic test

43% of cases involve a failure to thoroughly assess and evaluate symptoms

42% of cases involve a failure to establish a differential diagnosis list

A claim may have, and often does have, multiple breakdowns in the diagnostic care process that result in the missed or delayed diagnosis.

Constellation MPL claims reviewed 12/31/21

Case Example: Diagnostic Error

Failure to diagnose coronary artery disease leads to heart attack and death of a 39-year-old man.

A 39-year-old man with a history of diabetes, hypertension, smoking and pericarditis was examined by his family physician (FP) for chest discomfort and left shoulder pain. The FP noted the physical examination was normal, with a normal cardiac rate and rhythm, as well as full range of motion with some pain in the left shoulder. The FP's assessment included uncontrolled hypertension and pain in the joint of the left shoulder. The FP did not order any testing, but renewed the man's blood pressure medication prescription and made a referral for a cardiology appointment for chest and left shoulder discomfort, and history of pericarditis.

Two days later, the man had a sudden onset of chest pain and went to the emergency department (ED) of his local hospital. The ED physician placed him on a cardiac monitor that showed ventricular tachycardia. The man became unresponsive, and cardiac resuscitation was initiated. Despite resuscitation efforts, the man died. The cause of death was acute myocardial infarction secondary to coronary artery disease.

The family filed a malpractice claim alleging failure to timely diagnose coronary artery disease causing death. The experts who reviewed the care felt this man had multiple elevated risk factors for coronary artery disease, and that the FP should have done an EKG and included coronary artery disease in the differential diagnosis to rule out a potentially serious condition.

These contributing factors played a role in the allegation of failure to diagnose and are amenable to risk management strategies:

Initial diagnostic assessment: Patient assessment failure in evaluating history and symptoms. This patient's history should have been a red flag to establish a robust differential diagnosis list and rule out coronary artery disease.

Initial diagnostic assessment: Narrow diagnostic focus and lack of differential diagnosis list

Initial diagnostic assessment: Failure to order diagnostic tests to rule out a potentially serious cardiac condition

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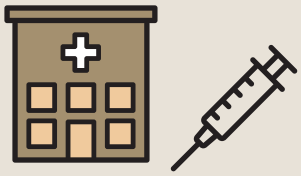

Top Risk Driver in Clinics—Medical treatment allegations

In the clinic setting, medical treatment allegations account for 34% of claims and 24% of costs. The majority of these claims fall into two categories—improper performance of a procedure (43%) and improper management of a medical treatment (43%). These claims usually involve routine, common procedures such as injections, venipunctures, spinal taps and biopsies.

In the Clinic

Medical Treatment Allegations are

#1 in OCCURRENCE **#2 in COST**

Just over half (52%) of medical treatment claims involve technical skill problems during the performance of the procedure as a contributing factor. Often, there are problems with skill combined with clinical judgment issues, communication breakdowns with the patient, or patient behavior-related issues such as noncompliance with the treatment plan.

Medical Treatment Top Contributing Factors

A single harm event may involve multiple contributing factors.

Constellation MPL claims reviewed 12/31/21

Case Example: Medical Treatment

Improper resuscitation following improper performance of an occipital nerve block leads to a woman's death.

A neurologist treated a 42-year-old woman in his clinic for over two years with occipital nerve blocks for chronic headaches due to a past motor vehicle accident. During a treatment, the patient lost consciousness and the neurologist could not feel her pulse. He began CPR, and his nurse called 911. EMS arrived within 15 minutes and detected a pulse. They transported the woman to the local ED. On the way, she suffered another cardiac arrest. She died four days later after brain death was confirmed and life support was withdrawn.

Her family filed a malpractice claim against the neurologist alleging improper performance of a medical procedure and improper management of her resuscitation. The experts who reviewed the neurologist's care were critical of the resuscitation efforts because no IV was started and no epinephrine was given. They felt the cardiac arrest was caused by the inadvertent injection of the bupivacaine intravascularly.

These contributing factors played a role in the allegations of improper performance of the procedure and improper management of medical treatment and are amenable to risk management strategies:

Clinical judgment: Improper selection of treatment during resuscitation

Technical skill and performance: Inadvertent intravascular injection of bupivacaine during occipital nerve block

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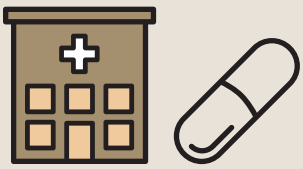


Top Risk Driver in Clinics—Medication allegations

Medication allegations represent 12% of claims and 18% of costs in the clinic setting. Medication errors can occur during any stage of the medication process—ordering, dispensing, administering and monitoring.

The majority of medication allegations (47%) concern improper medication regimen management. These claims involve adverse effects and drug interactions of prescribed medications that should have been managed by monitoring medication effects and lab values. An ordering error was involved in 18% of these claims, including giving a wrong dose or wrong medication. Administration errors, such as injections at the wrong site or medication administered by the wrong method, were involved in 11% of cases.

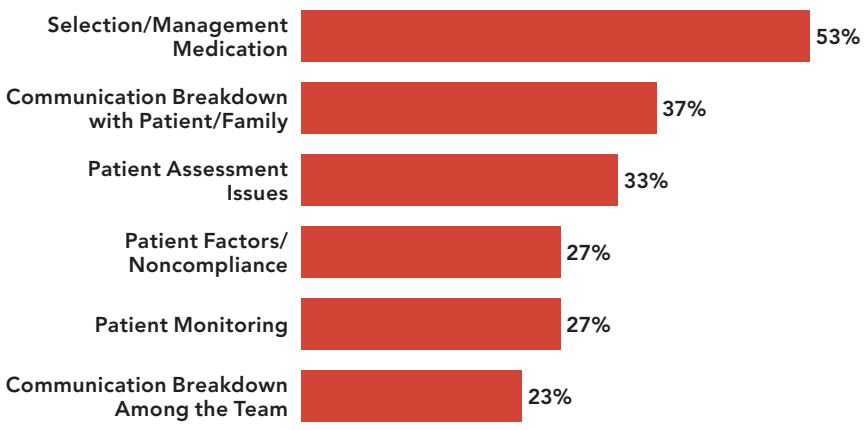
In the Clinic

Medication Errors are

#3 in COSTS **#4 in OCCURRENCE**

The leading factors contributing to medication error claims include clinical judgment issues with the selection or management of a medication (53%) and with patient assessment (33%), as well as monitoring issues (27%). Communication breakdowns were also frequent, both with the patient (37%) and among the care team (23%)

Medication Errors Top Contributing Factors



A single harm event may involve multiple contributing factors.

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Case Example: Medication Error

A woman dies from a hemorrhage after clinicians fail to monitor her anticoagulant levels.

A 73-year-old woman was examined by a nurse practitioner (NP) at the patient's usual primary care clinic for complaints of intermittent dull low back pain. The woman had been on anticoagulant therapy for a number of years because of a history of congestive heart failure, mitral valve stenosis and atrial fibrillation. The NP prescribed an antibiotic for a presumed urinary tract infection and advised the woman have her INR (international normalized ratio) labs done in two days to monitor her anticoagulant therapy.

At that visit, the woman's INR level was high, and she complained of blood in her urine. A family physician (FP) administered vitamin K to counteract the high INR level and prescribed a second dose for that evening at home. He also discontinued her anticoagulant but continued the antibiotic.

The next morning, the woman's INR value remained high, and the FP advised her to go to her local ED the next morning to have labs rechecked because the clinic was closed on weekends. Later that afternoon, the woman presented to the ED with complaints of dizziness and blurred vision. The ED clinician diagnosed an intracranial hemorrhage and admitted her to the hospital.

As a result of the hemorrhage, the woman suffered vision impairment, balance difficulties, mental confusion and difficulty with both oral and written communication. She filed a malpractice claim against the clinic and its clinicians for improper medication regimen management.

The experts who reviewed the care were critical of the NP for the antibiotic choice (contraindicated with the woman's anticoagulant) and for not decreasing the anticoagulant dose when prescribing the antibiotic. They were critical of the FP for failing to timely treat the elevated INR levels with hospitalization.

These contributing factors played a role in the allegation of medication error and are amenable to risk management strategies:

Selection/management of medication: Failure in the selection of medication due to contraindications with the anticoagulant

Patient monitoring: Failure to order INR levels at the time of prescribing

Selection/management of medication: Anticoagulant dose was not decreased when prescribing the antibiotic

Patient monitoring: Failure to recognize/appreciate severe symptoms and elevated INR test results

Patient monitoring: Failure to recognize/appreciate severe symptoms and elevated INR test results

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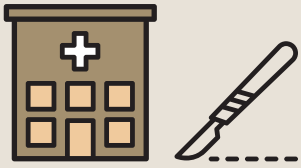


Top Risk Driver in Clinics—Surgical allegations

Surgical allegations represent 14% of clinic claims and 10% of costs. These claims mostly involve orthopedists and specialty surgeons, and primarily include allegations of improper surgical patient management. Improper surgical patient management allegations comprise the pre-, intra-, and postoperative phases of surgical care.

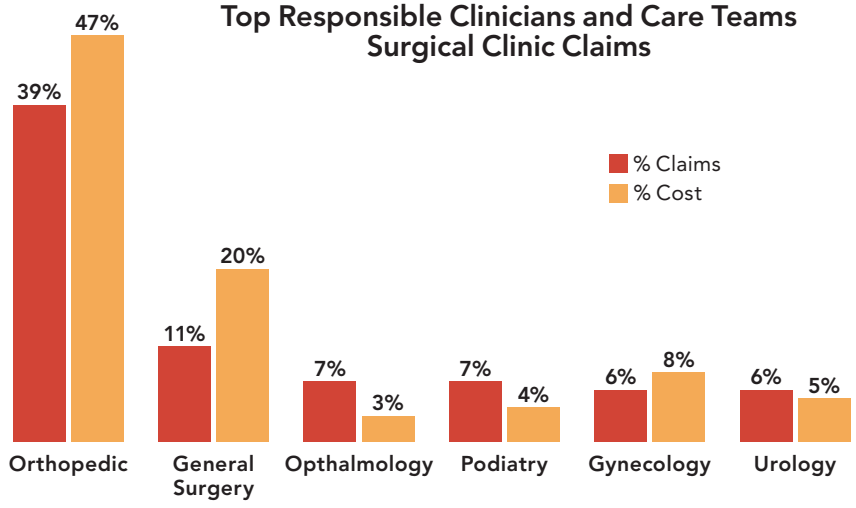
In the Clinic

Surgical Allegations are

#3 in OCCURRENCE **#4 in COST**

Nearly half (47%) of surgical claims originate from allegations of improper care by orthopedic physicians and their care teams. General surgery care teams were second in cost incurred, but the incidence of those claims was roughly half that of orthopedic claims. Injuries resulting from improper surgical patient management include infection, pain, malunion/nonunion, and nerve and organ damage.

Top Responsible Clinicians and Care Teams
Surgical Clinic Claims



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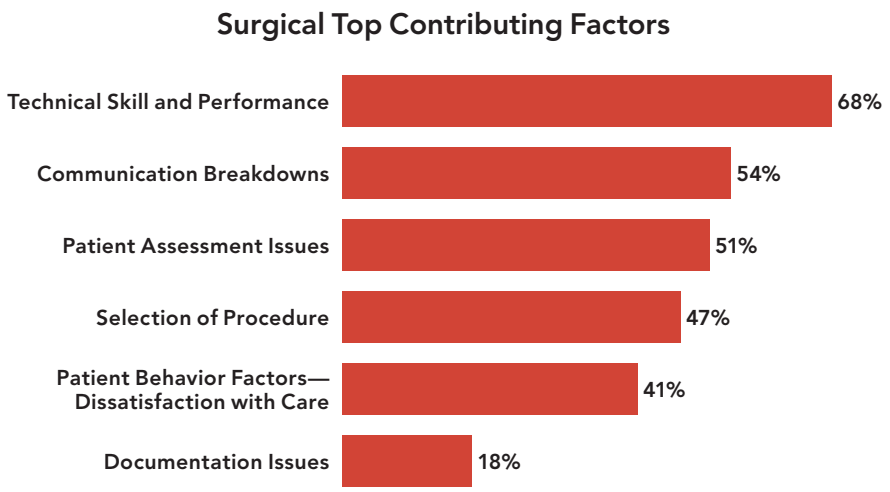
More than two-thirds (68%) of surgical clinic claims involved errors in technical skill and performance, including known risks of the surgical procedure. Combined with the communication breakdowns, this represents an opportunity to improve the informed consent process in the clinic prior to the surgical procedure.



A single harm event may involve multiple contributing factors.

Constellation MPL claims reviewed 12/31/21

Case Example: Surgical Allegations

Poor assessments and communication breakdowns postoperatively lead to permanent nerve damage in a 60-year-old man.

An orthopedic surgeon performed a right total knee arthroplasty on a 60-year-old man with a history of knee pain and osteoarthritis. Six days later on a Friday afternoon, the man called the orthopedist's office complaining of pain and swelling in his right knee and calf. The office team member did not communicate with the orthopedist but told the man to keep his orthopedic appointment the following week and to follow the postoperative instructions to use ice and elevation for swelling. The next week, the orthopedist examined the man, who was still complaining of right lower leg pain, swelling and weakness. The orthopedist ordered a duplex exam, which showed no evidence of a deep vein thrombosis. Over the next several weeks, the man continued to complain of pain, swelling and weakness in his right lower leg, for which he called the orthopedist's office several times.

Six weeks after surgery, the man went to his local hospital ED with complaints of right lower leg pain, swelling and weakness. The ED physician ordered a Doppler ultrasound of the right knee, which showed a pseudoaneurysm of the popliteal artery. A vascular surgeon was consulted, and he performed a repair of the pseudoaneurysm. The man suffered a permanent nerve injury and foot drop. He was unable to return to work and later filed a malpractice claim against the orthopedist alleging improper performance of surgery and failure to obtain informed consent.

The experts who reviewed the care felt that the popliteal artery was injured during surgery, causing the man to develop the pseudoaneurysm, which put pressure on the peroneal nerve, leading to the nerve injury and foot drop. The experts were critical of the delay in diagnosing the pseudoaneurysm, considering the man made repeated complaints of pain, swelling and lower leg weakness. The experts were also critical of the orthopedist's office team in the handling of the man's repeated telephone calls complaining of continued symptoms. The involved orthopedic office team members testified that they did not have formal telephone triage protocols to manage postoperative patients.

These contributing factors played a role in the allegations of improper surgical patient management and improper performance of a procedure and are amenable to risk management strategies:

Patient assessment issues: Lack of adequate assessment and failure to recognize signs and symptoms of a known procedural risk

Communication breakdowns among the team with the failure to consult the surgeon.

Patient assessment issues: Failure to recognize signs and symptoms of a procedural complication and overreliance on negative test result

Patient assessment issues: Narrow diagnostic focus leading to failure to establish a differential diagnosis list

Patient assessment issues: Failure to respond to repeated complaints and symptoms

Patient assessment issues: Failure of care team to appropriately triage and respond to postoperative complaints

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In the Clinic:
Risk Management Tips

- ☑ Provide clinical decision support tools to help your clinicians and care teams:
  - – Consider and rule out potentially serious diagnoses.
  - – Assess a patient's risk for surgery, procedure or medications.
  - – Select appropriate treatment for commonly seen conditions.
  - – Triage a patient's symptom-related complaints to rule out potentially serious conditions.
- ☑ Assess your follow-up and test management systems to find gaps in follow-up care and in monitoring diagnostic tests and medication levels.
- ☑ Enhance teamwork and communication skills with training and use of communication tools such as SBAR.
- ☑ Use simulation training to ensure technical skill and competence in performing surgical and routine procedures, as well as in equipment use.
- ☑ Educate patients; obtain and document informed consent for surgery, procedures and medications with material risks using a patient-centered, shared decision-making approach.
- ☑ Provide education for clinic team members responsible for telephone or electronic communications with patients regarding symptoms or postoperative questions.

To access resources to mitigate risk in the clinic setting, sign in to ConstellationMutual.com > Risk Resources > Bundled Solutions

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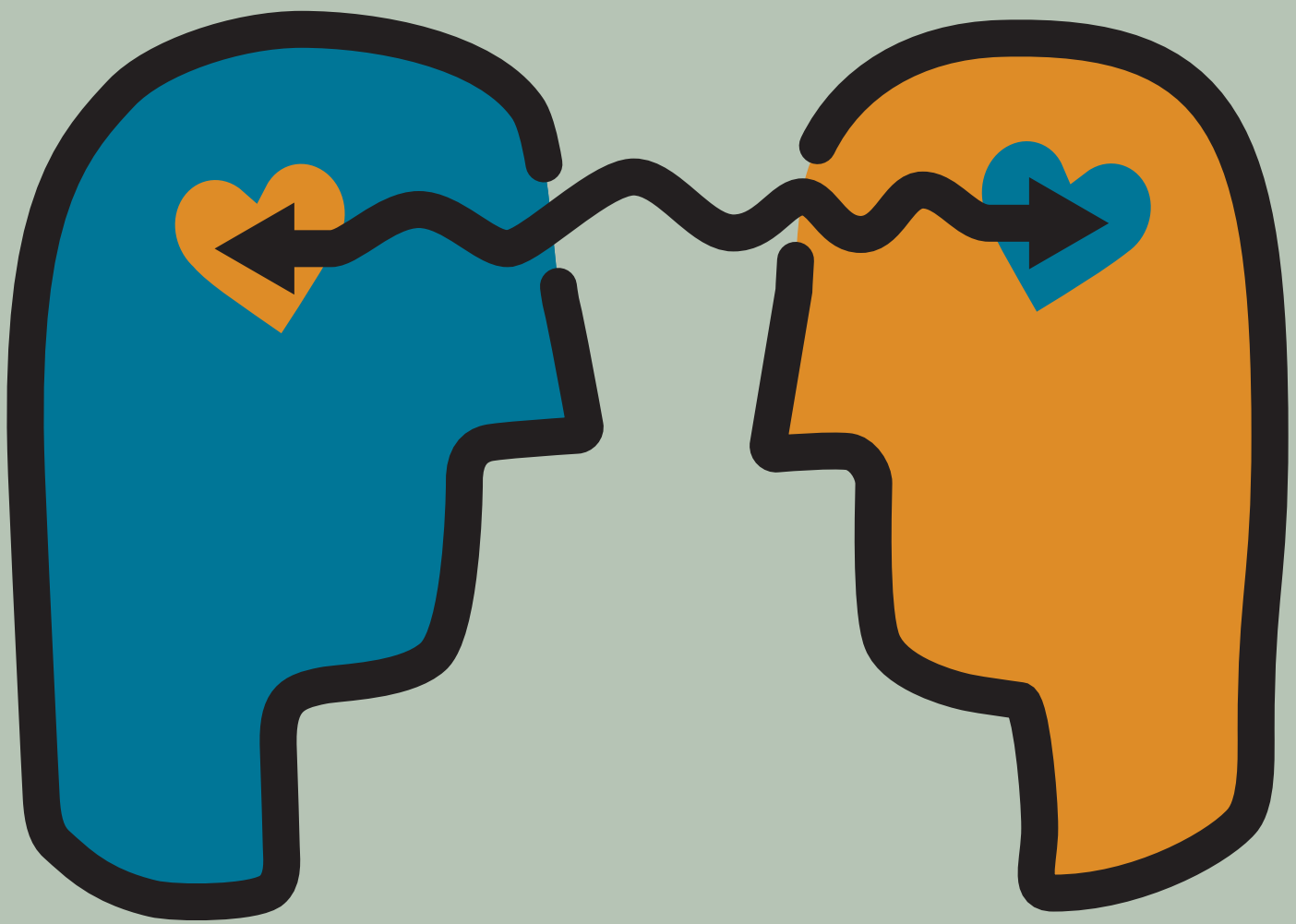
It’s Time to Talk

Empathy training and practice are key to being prepared for the crucial moments after a harm event.

By Lauri Hopple, Freelance writer



The man in the video is visibly agitated, expressing anger and frustration about his chronic pain after a surgical incident. The clinic administrator tries repeatedly to reason with him. "You're not listening!" the man shouts.

Did the administrator manage to turn this increasingly hostile meeting into a productive discussion? In a role-playing video presented during Constellation's April 2022 webinar, "Communicating After Harm Events: Applying Learnings to Real-Life Scenarios," the answer was yes, but only because the adminstrator had training in empathetic communication.

Traci Poore, JD, CPHRM
Sr. Risk Consultant
Constellation

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Risk Consultant
Constellation

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Most clinic administrators, clinicians and care team members, however, haven't had that sort of training, according to Traci Poore, JD, CPHRM, the senior risk consultant for Constellation who played the administrator in the video exercise. Poore and webinar co-presenter Michael Turturici, also a risk consultant, explain in the webinar that how to have empathetic discussions isn't usually taught in medical or nursing school, leaving many clinicians ill-prepared to navigate the often emotionally charged aftermath of a harm event. This lack of training can lead to potential misunderstandings, mistrust, negative experiences and, ultimately, possible legal actions.

In an informal poll during the webinar, only 21% of participants said their organizations provide any type of training to help care teams communicate with patients, families and senior living residents after a harm event. Fortunately, Constellation's risk consultants and our early intervention program, HEAL, can provide resources to help clinicians prepare for these sensitive and challenging conversations.

"Care team members participating in these conversations really need to be coached in a supportive environment," Turturici says in the webinar.

Using several real-case scenarios, Poore and Turturici define empathetic communication and explore how care teams can not only train but also practice these tough discussions. That's the best way, they say, to learn the skills required for those crucial moments after an accident or mistake happens in a clinic, hospital or senior care setting.

Defining empathetic communication

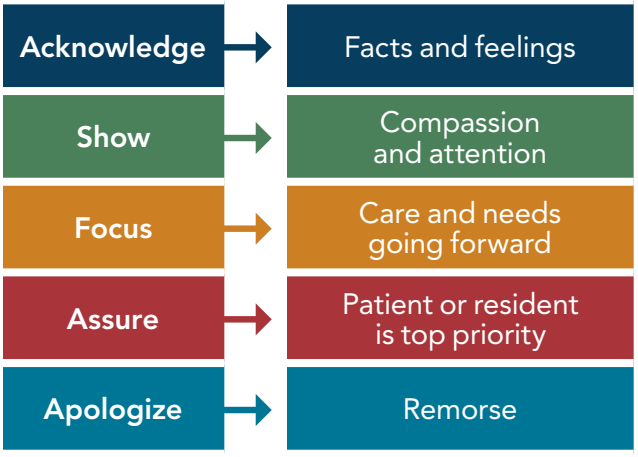
After a harm event, patients, senior living residents and families need truthful, accurate and timely information about what happened. And they need to know that the initial conversation is just that: a first step. It's important for them to understand that the care team will include them in ongoing conversations about future care and about the investigation into the event. Simple steps like exchanging contact information will reassure them they'll remain in the loop.

"Patients and families need assurances that they are your priority," Turturici says.

Just as important is a heartfelt apology. "They want to hear we're sorry for what happened and what they are going through," Turturici explains, adding that expressing remorse can go a long way toward maintaining trust.

To help shape these difficult initial conversations, Poore and Turturici emphasize keeping the focus on what the patient and family need. They suggest using the following five-step action plan.

5-step Communication Action Plan



1. **Acknowledge:** Share the objective facts of what is known about the event at that time, while also acknowledging the emotions surrounding the event. Allow time for and invite questions; it's okay not to have all the answers, but be sure patients, families and residents know to expect answers as soon as they are known. Avoid speculation and blame, and do not minimize emotions.

2. **Show compassion:** Invite and accept the feelings of all parties. Give them your full attention by sitting down, turning off your phone and minimizing other interruptions. Make eye contact and avoid defensive body posture, such as crossed arms or legs.

3. **Focus:** Ensure the focus remains on medical care needs, ongoing care and realistic expectations, and again allow time for the patient, resident or family to process and ask questions.

4. **Assure:** Set up a next meeting, and provide a contact person that is readily available should the patient, resident or family have additional questions or needs. Explore what nonfinancial support might be needed, and show the patient, resident or family they are high-priority by setting follow-up expectations.

5. **Apologize:** Research indicates that patients, residents and families value a sincere and honest apology. A sincere apology does not necessarily mean admitting liability, but rather simply recognizing the adverse impact of the event on the patient, resident or family.

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Emotions, finances and legalities

An initial conversation may be the first time a patient, resident or family learns about the harm event, and it's often difficult to predict how they will react. Everyone responds differently to upsetting news, and how they react will depend on their communication style, their knowledge of medicine, their understanding of medical processes and, of course, their emotional state.

Turturici recommends using clear language and avoiding medical terms and jargon. As mentioned in the five-step action plan detailed above, acknowledging emotions such as anger, frustration or fear is paramount so the patient, resident or family feel heard.

Statements like "I understand how you feel," "I know what you're going through," or "I know how hard this is" can be presumptive and create or escalate anger or other emotions in a patient, resident or family member. Avoid being defensive, as defensiveness may be construed as arguing. Trying to establish who's right or wrong can also backfire, heating up a discussion already fraught with emotion.

Obviously, emotions can move quickly into negative territory. The clinician leading the discussion can and should set limits as to what is tolerated. The care team should feel safe, with full access to exits and, if needed, security nearby but outside the room. Always include more than one team member in these scenarios; the discussion leader might choose a patient advocate or a nurse to help manage emotions and to help keep track of the conversation.

One of the most useful tools is the pause, Turturici says. If the emotions are such that the conversation becomes counterproductive, it's appropriate to set up a time to regroup and continue the discussion later. During the video mentioned at the beginning of this article, Poore manages to diffuse the patient's anger by first taking a break, then acknowledging that she's been taking the wrong approach with the patient.

"I'm a factual communicator," Poore says. "I like logic. I take the emotion out when I have conversations or if I'm in a difficult kind of scenario. I really had to reroute my style of communication to meet this patient where he was."

Poore's efforts resulted in a fruitful discussion of how the care team could best support the patient, by providing information and referrals for ongoing care to try to resolve his chronic pain.

But what if a patient, resident or family member demands a lawyer be present? A request for an attorney or a threat to sue often masks underlying feelings of fear, guilt and lack of control. The key is to remain neutral, acknowledge the request and offer a choice along the lines of an example presented in the webinar: *"I respect your right to consult an attorney. Would you like to know what our plan is going forward before we involve counsel, or would you like to have this conversation later?"*

Poore suggests reiterating that this communication is not meant to prevent the patient or resident from seeking legal advice, but to disclose information about the event and the plan going forward.

Training, practice and feedback

Following is a basic role-playing exercise (based on two real-case scenarios, with potential responses provided) that was used for training purposes in the April webinar for administrators, clinicians and care teams. In the webinar, Turturici and Poore boil down the elements of the training to three basic components: discuss, practice and give feedback.

Case 1:

A 14-year-old boy is examined in a primary care clinic for a sports physical. The boy's parents consent to him receiving care alone in the room. During the examination, the boy points out a skin lesion that is bothering him, and the clinician who is examining him removes it. The lesion is sent to pathology, and the results return as cancerous. However, the results are not communicated to the boy or his parents.

Six months later, the pathology report is discovered when the boy returns along with his parents to be examined for a sports injury. Upon hearing about the delay in diagnosis, the boy's parents want to know if this six-month delay will make a difference in his treatment plan and prognosis.

The possible responses:

In this real-case scenario, what would be the best response for the clinician to give?

A. "I recommend we get a specialist involved to better understand the impact and what to do next. Would you be OK with me referring you to a specialist?"
B. "Six months is a very short amount of time considering the skin lesion was present for years. I suspect there will be no difference."
C. "I did some research and I'm certain there is no difference in the treatment plan or prognosis."
D. "I don't know. I recommend you speak with a specialist."

Case 2:

Patient A is a 56-year-old post-op patient on medication for mild chronic hypertension. Patient B in the next room is being treated with the same medication at a higher dose, as well as some additional medications for other chronic conditions. Unfortunately, Patient A receives all of Patient B's medications and as a result has altered vital signs requiring extended hospitalization for further observation.

Patient A seems calm and accepting of the mistake, but their spouse is angry and crying. The spouse wants the nurse who administered the medications to be fired, and wants a new nurse assigned to ongoing care.

The possible responses:

In this real-case scenario, what would be the best response for the clinician to give?

A. Ignore the spouse, as the patient is your main priority.
B. Assure the spouse that if a different care team is what the patient feels is best, you will accommodate them to the best extent possible.
C. Assure the spouse that the care team is competent, well trained and ready to continue care.
D. Inform the spouse that with current staffing levels, change in staffing would be difficult to accommodate.
E. Inform the spouse that there have been other problems with the administering nurse, and that you will investigate immediately.

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The training exercise:

If you would like to try these exercises on your own: Gather a group of five or six care team members and assign them one of the two scenarios above to role-play. Decide who will play what roles, such as patient or family member, administrator, patient advocate or social worker, nurse manager, and doctor or other care team member. Before beginning the exercise, the team should discuss the potential issues and reactions that might arise in a conversation immediately following a harm event, and they should consider appropriate responses based on the five steps of the Communication Action Plan (see page 14).

The best responses: If you choose to try this exercise, find the answers at the bottom of this article.

Repeated practice of these and other role-playing scenarios will help team members become more comfortable having difficult conversations with patients. Just as crucial is being able to give and receive honest and constructive feedback.

"It's really important to digest what happened in each scenario," Poore says. "What do you feel like you could do better?"

Being able to discuss how the exercise went, what went well and how team members can improve are key elements in feeling confident when a care team faces a real harm event in the future.

The Early Intervention HEAL Prepare Toolkit

The communication training and instruction used in these role-playing scenarios is available to Constellation customers. Constellation's early intervention program, HEAL, is an innovative partnership that is leading the way in the medical professional liability (MPL) insurance industry. HEAL helps care teams and organizations prepare for harm events before they happen, ensuring that people and processes are in place for an effective response. We know that unexpected outcomes, mistakes and harm events are inevitable. How we react in the first moments determines whether we preserve trust, communicate, learn and improve.

When harm events occur, HEAL offers a better way forward with transparency, compassion and the goal of early resolution. HEAL enables care teams and organizations to move forward after harm events to heal, learn and improve.

Members of the Constellation team have been formally trained in empathetic communication. To learn more, watch the April 2022 webinar, "Communicating After Harm Events: Applying Learnings to Real-Life Scenarios," and access HEAL Prepare Toolkit resources by signing in to ConstellationMutual.com > Risk Resources > HEAL Prepare Toolkit > Unit 3: Communicating After Harm Events.

How Constellation Helps Clinics and Their Care Teams

Constellation provides best practice guidance and communication training with role-playing scenarios, in which clinicians, clinic administrators and care teams can practice empathetically communicating after an unanticipated harm event. This innovative training involves a series of role-playing exercises and includes curveballs reflective of real-life situations. The training provides an interactive, hands-on experience for participants to ensure they're prepared for harm event conversations.

Case examples: The answers

Below are what Poore and Turturici recommend as the best possible responses to the real-case scenarios detailed in the article, along with key takeaways about each situation.

Case 1: Answer: A. "I recommend we get a specialist involved to better understand the impact and what to do next. Would you be OK with me referring you to a specialist?"

In this example, the answer doesn't speculate about what treatment could have happened during the delay, but it acknowledges that consulting a specialist could be a potential option. It also invites the parents to have a voice in the decision.

Case 2: Answer: B. Assure the spouse that if a different care team is what the patient feels is best, you will accommodate them to the best extent possible.

In this particular case, you should acknowledge the spouse's feelings and assure the spouse and patient that your priority is maintaining ongoing care. Ultimately, it's the patient's decision, and you will support whichever decision the patient and spouse work out together, even if you believe a staffing change isn't really necessary. Never discuss staffing issues, competencies, training or discipline with a patient, resident or family member.

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Freelance writer

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A Unique Podcast Sparks Change

How the conversations in the "Off the Charts" podcast about diversity, equity and inclusion can improve clinical practice.

By Sue Campbell, Freelance health care writer

George Floyd's murder made Kari Haley, MD, wonder how first responders were coping with the event and its aftermath in her Minneapolis-area community. At the time, Dr. Haley was assistant medical director of Regions Hospital Emergency Medical Services for HealthPartners, the country's largest consumer-governed, nonprofit health care organization.

JEFF JONDAHL

To find out, she organized a roundtable discussion of a dozen firefighters, EMTs, paramedics, nurses and doctors. That group, made up of both Dr. Haley's colleagues and community emergency workers, shared stories about racism they'd encountered personally and professionally. Communally, they processed their experiences, fears and hopes for the future.

That powerful conversation, which was recorded, caught the attention of Jimmy Bellamy, senior communications consultant for HealthPartners. Soon after, Bellamy emailed Dr. Haley for permission to share the roundtable across HealthPartners's social media channels. As she agreed to that plan by email, Dr. Haley copied Steve Jackson, MD, who specializes in patients with spinal cord injuries and co-chairs HealthPartners' Equity, Inclusion and Anti-Racism Cabinet.

Dr. Haley knew Dr. Jackson was continually looking for ways to further diversity, equity and inclusion (DEI) goals, including fostering an environment of welcoming, including and valuing everyone who walked through any door in the organization. Dr. Haley started thinking about how to keep the momentum she felt from the roundtable going and growing, and she figured Dr. Jackson could help.

"We should do a podcast," she wrote in that email.

Without hesitation, Dr. Jackson said yes.

After some brainstorming, "Off the Charts: Examining the Health Equity Emergency" was born.

"It's been a complete grassroots effort," Bellamy says. "It was: 'We're doing this.' And everyone from leadership on down has been supportive."

Bellamy thinks it's a first. "I've searched Apple and other podcast platforms," he says, "and I could not find another ongoing podcast hosted by a health care system dedicated to DEI."

The Clinical Connection

Over the past two years, Drs. Haley and Jackson have recorded more than 16 episodes of "Off The Charts," speaking with guests about persistent DEI disparities in health care and what

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can be done to bring about equity. They've tackled childhood immunizations, microaggressions, cultural humility and what it means to be a bystander rather than an "upstander" when confronting racism.

They hope their conversations will lead to improved patient care in clinical settings by helping to deepen empathy, understanding and, especially, trust.

One example of how this works: Black women experience poor maternal health outcomes at a significantly higher rate than white women. The "Off the Charts" podcast on that topic featured Dr. Corinne Brown-Robinson, the vice chair of the OB-GYN department and medical director of the ultrasound department at HealthPartners. When delivering her own twins, Dr. Brown-Robinson experienced racism as a maternity patient in the hospital that employed her at the time. It happened during postpartum care, when a worker questioned whether Dr. Brown-Robinson was truly a doctor.

Such offensive or unthinking remarks can break the trust that a patient has for her providers and the system.

"All who play a role in patient care, regardless of role, are all affecting patient care," Dr. Jackson says.

Trust is a recurring theme

"Trust is built within the culture of the clinic itself," Dr. Haley says. Dr. Jackson elaborates, "It's how people are greeted, checked in, directed to where they should go in the clinic. It's how they're perceived when they come into the building and when they see their providers. There's a continuum of trust that every piece and player needs to be on board for."

Drs. Haley and Jackson see the podcast itself as a vehicle for building the trust needed to provide a positive environment both for workers and for optimal patient care. By hearing others' stories, a listener's perspective can shift. That in turn can lead to challenging assumptions, thinking differently and behaving mindfully. Perhaps a health care worker then chooses not to make a comment that could break trust, or maybe a patient decides to be more open-minded about a doctor who is different from them.

"We're creating a space where difference is talked about openly," Dr. Jackson says. "These conversations hit real issues hard, but without big fancy words. We dispel myths and rumors about doctors and the health care system. We also give a voice to community members who might not have one in the health care space."

In fact, a forward-looking goal of the podcast is to engage more community members as guests; because of the COVID-19 pandemic, "Off the Charts" has so far used primarily HealthPartners professionals.

Dr. Haley speaks of the bravery it takes for guests to share personal stories about health and racism. She thinks the courage shown by those who come on the show will "spark the courage to start conversations within people's own groups. It's being open to conversations about how others experience the world, especially as it has to do with health and providing care."

She and Dr. Jackson also make a point of selecting guests who are both knowledgeable and vulnerable, who are open to sharing their wisdom along with their experiences. And, of course, they look for great storytellers.

Patient-centered and beyond

Bellamy describes the podcast's audience as "the DEI-curious"—people who know inequity exists and want to learn, but who perhaps fear difficult conversations around race.

Dr. Jackson sees the audience more broadly: "We want to talk to those who perpetuate disparities, and those who have suffered the negative effects; the single mom who feels like she has no voice, the dad who goes into the office and is ignored. We want to reach anyone who listens to podcasts."

That's because he believes anyone can benefit from hearing these conversations, including himself.

"I drank the proverbial Kool-Aid," Dr. Jackson says of his belief in HealthPartners' values of excellence, compassion, partnership and integrity. He truly believes in and tries to live by those values, and by the organization's vison of "Health as it could be, affordability as it must be, through relationships built on trust."

He and Dr. Haley see the "Off the Charts" podcast as amplifying those values and showing how they can be made real across a range of care situations.

One early episode explained the practice of cultural humility. Guest Miguel Ruiz, MD, a hospice and palliative care physician, spoke about how care providers can seek to understand rather than simply being understood. In that episode, not only did Dr. Ruiz tell stories about patients who showed how they could feel vulnerable or misunderstood, but he also outlined steps providers could take in their approach that will better serve their patients.

For Dr. Jackson, the Dr. Ruiz episode showcases how every episode of "Off the Charts" loops back to improved outcomes in a system that's being sensitized to issues of inclusion.

"This is a patient-driven, patient-centered project," he says of the podcast. "If you think about it, why else would we do it? I can't think of a better reason other than to eventually lead to improved patient care."

To find episodes of "Off the Charts," visit bit.ly/HealthPartnersOffTheCharts

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HEAL Review

Spotlighting cases that benefit from Constellation's early intervention services

Failure to See Warning Signs

A 75-year-old woman with multiple medications and kidney disease develops kidney failure after her physician prescribes an arthritis medication he should have recognized as contraindicated.

SPECIALTY	ALLEGATION	RISK MITIGATION FOCUS
⁄ Family Practice	⁄ Improper medical treatment	⁄ Mitigating medical treatment harm events ⁄ Early intervention

Improper medical treatment is the

2nd

most frequent malpractice allegation*

*Across all settings, including clinics

Facts of the case

A 75-year-old woman with chronic kidney disease and high blood pressure sought care for arthritic leg pain from her family physician (FP). The FP prescribed a NSAID (nonsteroidal anti-inflammatory drug) for her leg pain. He was also already prescribing an ACE (angiotensin-converting enzyme) inhibitor and a diuretic for her high blood pressure. After taking the NSAID for a year, the woman developed a gastrointestinal bleed and was hospitalized. At that time, she was also diagnosed with kidney failure. She was transferred to a tertiary hospital where dialysis was begun. The nephrologist commented that the combination of the NSAID and her blood pressure medications pushed her into kidney failure and that she will need dialysis three times a week for the rest of her life.

The woman contacted the FP and complained that he improperly managed her medical treatment. She alleged that the FP failed to appreciate the risks of using NSAIDs for pain in a patient with chronic kidney disease, failed to inform her about these risks, and failed to appropriately monitor her kidney disease—all causing kidney failure.

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Disposition of the case
The case was closed with a payment to the patient on behalf of the FP.

Early intervention outcome
After this harm event was reported to Constellation, we conducted a thorough case review as part of our early intervention program, HEAL. The experts who reviewed the care were critical of the FP for not recognizing that NSAIDs, diuretics and ACE inhibitors carry the risk of kidney injury, especially when they are prescribed together over an extended time. During the review, the FP acknowledged that he did not appreciate or discuss with the patient the risks and benefits of using these drugs together given her chronic kidney disease.

Because Constellation was made aware of this event through early reporting, we were able to quickly conduct an expert review. The expediency with which we conducted this review helped us to determine our next steps. In this case, we made a fair offer of compensation to the patient to help all parties involved begin to heal, and we reduced the life cycle of the event. Without Constellation's early intervention, this case could easily have escalated to a lawsuit and taken many more months or even years to resolve.

Shortening the life cycle of a case alleviates clinician stress and anxiety, and lessens care team disruptions. This helps clinicians and care teams learn, move forward and get back to what matters most: providing safe, high-quality care.

Medical treatment harm events
In Constellation's recent review of malpractice claims, medical treatment allegations were found to be second in occurrence and fourth in costs across all settings. Medical treatment allegations occur in two main categories:

- 49% involve improper performance of a procedure.
- 38% involve improper management of medical treatment (as illustrated in the above malpractice claim).

While the majority of these harm events involve medium-severity injuries, 15% involve high-severity harm events like permanent injury (e.g., kidney failure) or death.

The locations of these claims are split between the clinic setting (39%) and the hospital setting (39%). Within the hospital, the top locations involved in medical treatment allegations include:

- Emergency department 28%
- Patient room 23%
- Special procedure areas 16%
- Radiology/imaging 9%

When allegations of improper performance of a procedure are made, these claims typically involve routine, common procedures such as:

- Scope procedures
- Injections
- Venipunctures
- Spinal taps
- Biopsies

Contributing factors in medical treatment claims
Contributing factors are those risk factors that contribute to the alleged harm event or filing of a claim and are amenable to risk mitigation strategies. Most harm events are the result of more than one contributing factor.

The primary contributing factors involved in medical treatment performance claims include:

1. Technical skill or poor technique, including the occurrence of known risks of the procedure
2. Improperly used equipment
3. Retained items (e.g., sponges, needle tips)

The contributing factors involved in improper management of medical treatment claims include:

- Patient assessment issues, such as failure to appreciate symptoms or delay in ordering tests
- Improper selection of therapy to treat a condition
- Communication breakdowns with patients and families

How Constellation can help
Unanticipated outcomes and adverse events happen. After all, clinicians and care teams are human, and even the most seasoned of them make errors. Unfortunately, these events often generate cascading ripples of hurt and cause additional harm in the absence of communication and clear steps forward.

At Constellation, we're on a mission to set the precedent for a better way forward after harm events—a way that can preserve relationships, promote communication and improve everyone's experience. ***Our early intervention program, HEAL, champions this better way forward***.

Constellation is prepared and ready to support our customer care teams, clinicians and health care organizations immediately following a harm event. We encourage customers to contact us as soon as possible when things don't go as planned, so we can offer our HEAL services.

Reporting a harm event as early as possible has important benefits. Early reporting prompts immediate access to:

- Thorough case review to provide peace of mind about the care provided
- Communication assistance to help clinicians and care team members talk with patients, senior living residents and families after an event
- Clinician peer support to help clinicians and care team members navigate the many landmines of a harm event, claim or lawsuit
- Risk consultation to help improve care processes to reduce or mitigate future harm events

And when our case review findings uncover that there were no issues with the care provided, we will defend good medicine.

Ultimately, early intervention can help:

- Enhance the trust between the patient or senior living resident, care teams and clinicians
- Reduce the chance of claims and lawsuits
- Reduce clinician and care team turnover
- Uncover lessons to mitigate future events

To learn more about Constellation's early intervention program, HEAL, and to assess your ability to respond effectively to a harm event like this one, sign in to ConstellationMutual.com to access the HEAL Prepare Toolkit and take the HEAL assessment.

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Reducing Medical Treatment Harm Events

- ☑ Use simulation training to ensure technical skill and competence in performing routine procedures and using equipment.
- ☑ Educate patients about procedures and medication treatment regimens with material risks using a patient-centered, shared decision-making approach.
- ☑ Implement a triage and communication process for office teams to address symptom-related patient concerns and respond appropriately.
- ☑ Mitigate the risk of retained items by implementing count procedures/technologies, and by reducing distractions when setting up for procedures, during procedures and at the conclusion of procedures.
- ☑ Provide clinical decision support tools to aid clinicians in selecting appropriate treatment for and monitoring of common medical conditions, as well as recognizing contraindications to medications.

For risk mitigation resources, sign in to ConstellationMutual.com > Risk Resources > Bundled Solutions

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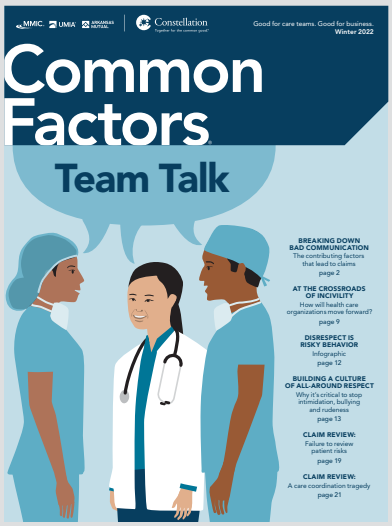

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