Anesthesiology: Claims Trends, Risk Issues, and Prevention Strategies

Today's program

Today's speaker is Dorie Rosauer, RN, MBA, Senior Patient Safety and Risk Consultant, MedPro Group (Doral.Rosauer@medpro.com)

A member of MedPro Group's national Anesthesiology Specialty Advisory Board, Dorie has managed the day-to-day organizational operations of quality, risk management, infection control, safety, self-insured retentions, and physician professional liability. During her recent years as a patient safety and risk consultant, Dorie's focus has been on identification and implementation of cutting-edge, proactive risk-reduction strategies.

Designation of continuing education credit

Medical Protective is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Medical Protective designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure

Medical Protective receives no commercial support from pharmaceutical companies, biomedical device manufacturers, or any commercial interest.

It is the policy of Medical Protective to require that all parties in a position to influence the content of this activity disclose the existence of any relevant financial relationship with any commercial interest.

When there are relevant financial relationships, the individual(s) will be listed by name, along with the name of the commercial interest with which the person has a relationship and the nature of the relationship.

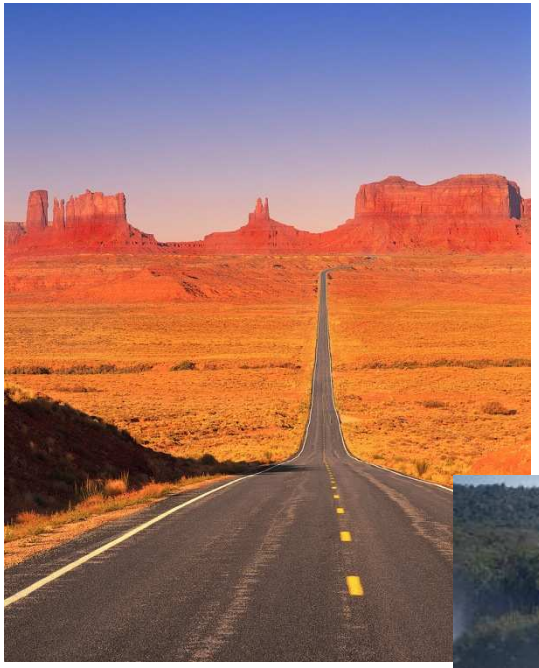
Today's faculty, as well as CE planners, content developers, reviewers, editors, and Patient Safety & Risk Solutions staff at Medical Protective have reported that they have no relevant financial relationships with any commercial interests.

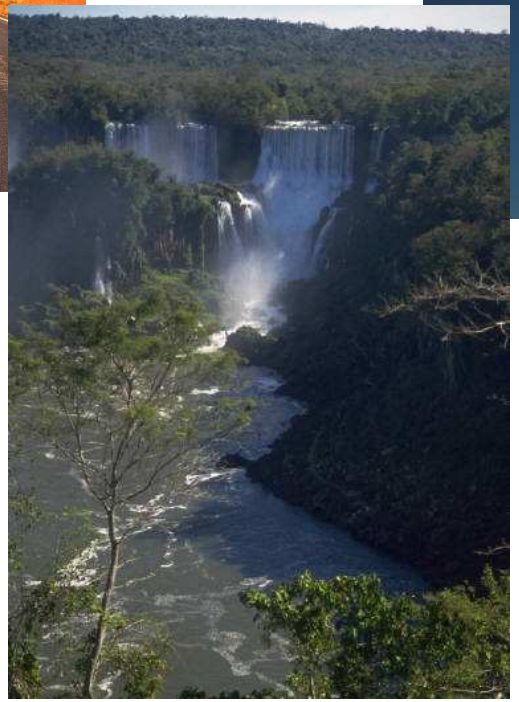
Objectives

At the conclusion of this program, you should be able to:

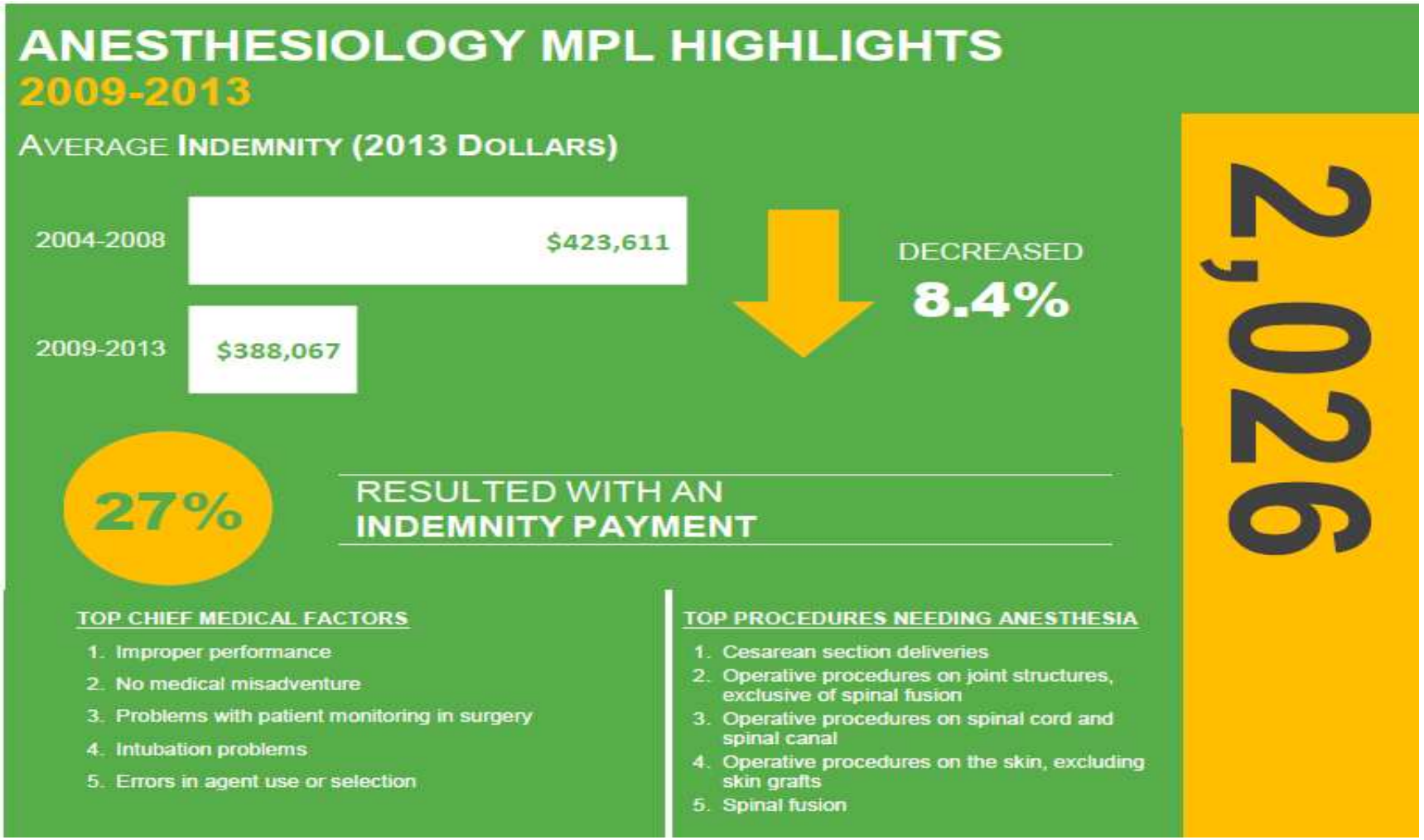
- Evaluate closed claims to identify issues with screening and management of patients who have diagnosed and undiagnosed obstructive sleep apnea (OSA)
- Discuss the importance of informed consent in anesthesiology practice
- Identify preoperative, intraoperative, and postoperative best practices, as well as best practices to avoid or manage dental claims
- Provide risk-reduction strategies to address patient complaints and refunds/waivers
- Identify disclosure strategies to manage adverse patient outcomes and medical errors

The landscape of anesthesiology claims



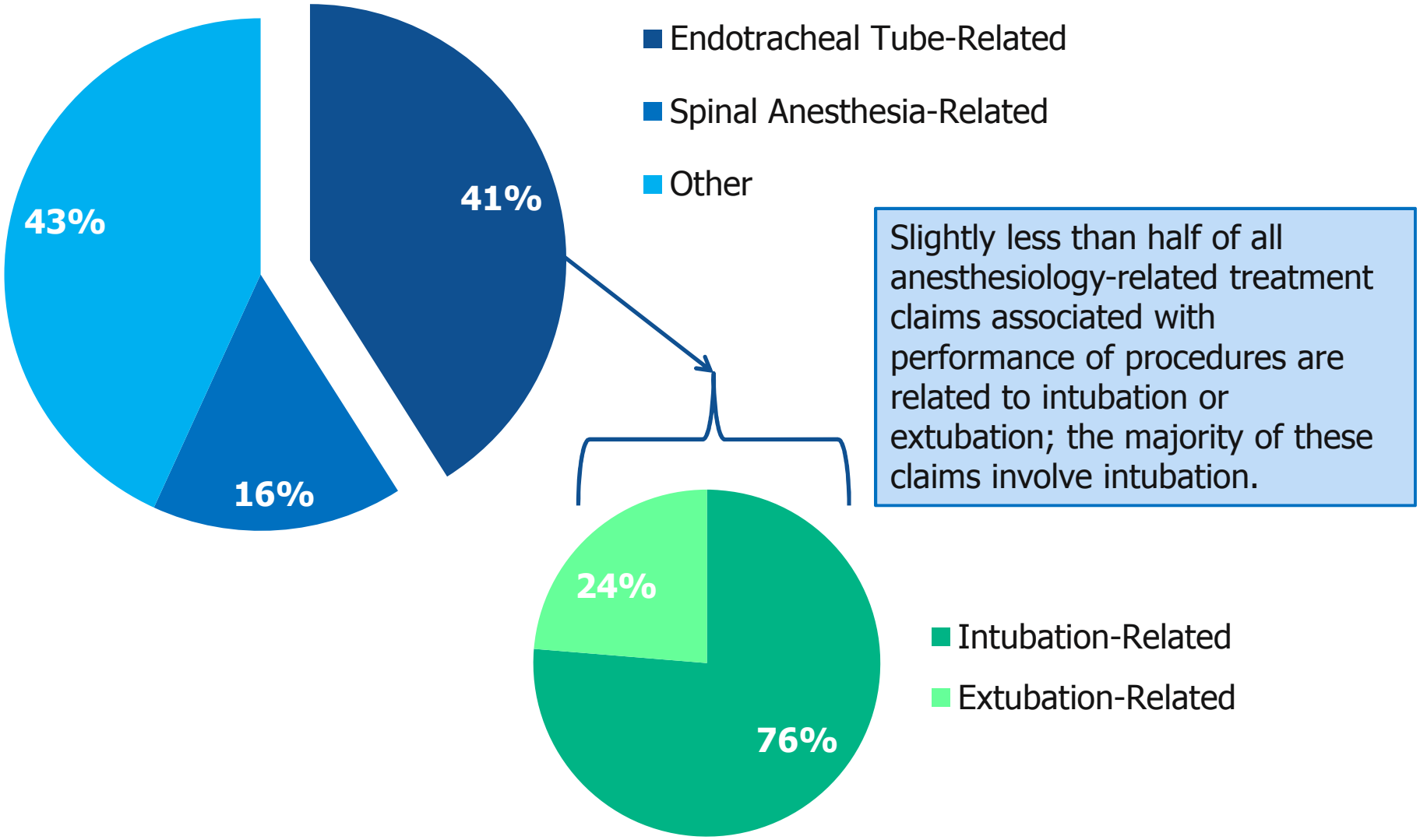


PIAA: current data highlights



PIAA Specialty Specific Series, 2014 Edition, January 1, 2004–December 31, 2013

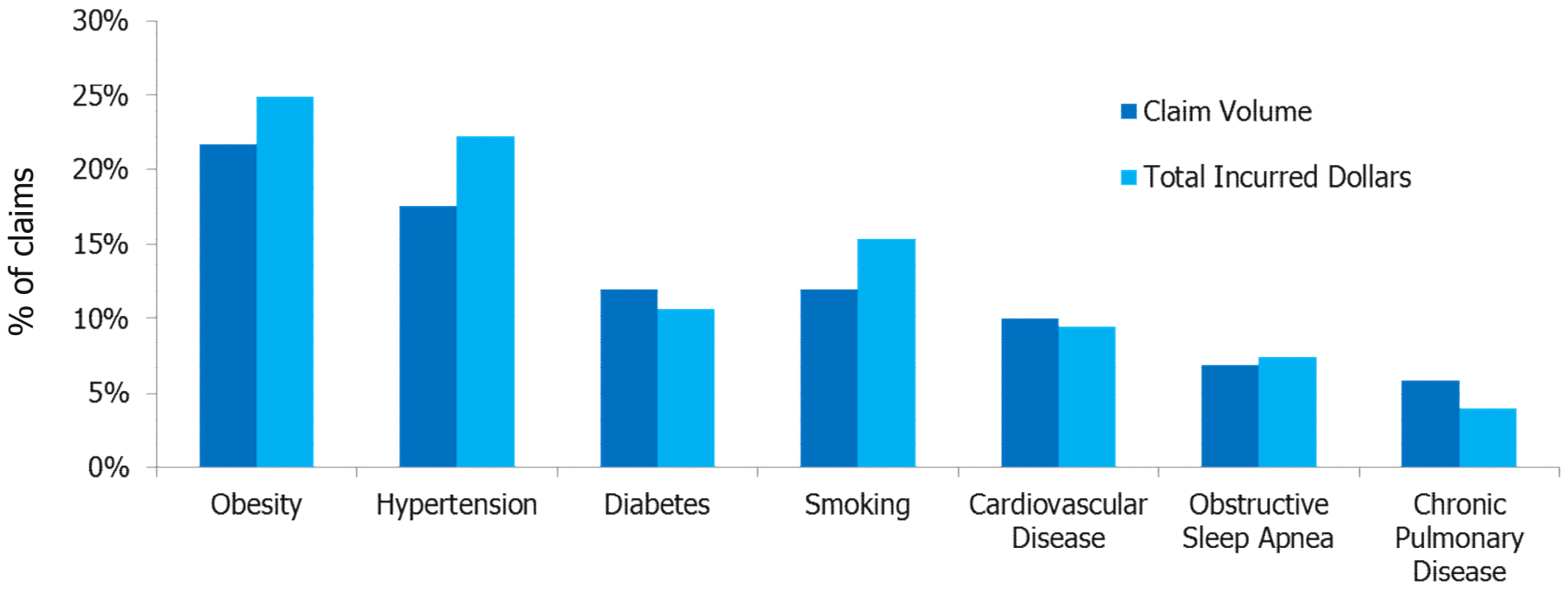
Anesthesia-related treatment: procedure types



Slightly less than half of all anesthesiology-related treatment claims associated with performance of procedures are related to intubation or extubation; the majority of these claims involve intubation.

MedPro Group claims data, 2004-2013 (anesthesiology as responsible service)

Anesthesia-related treatment: patient factors

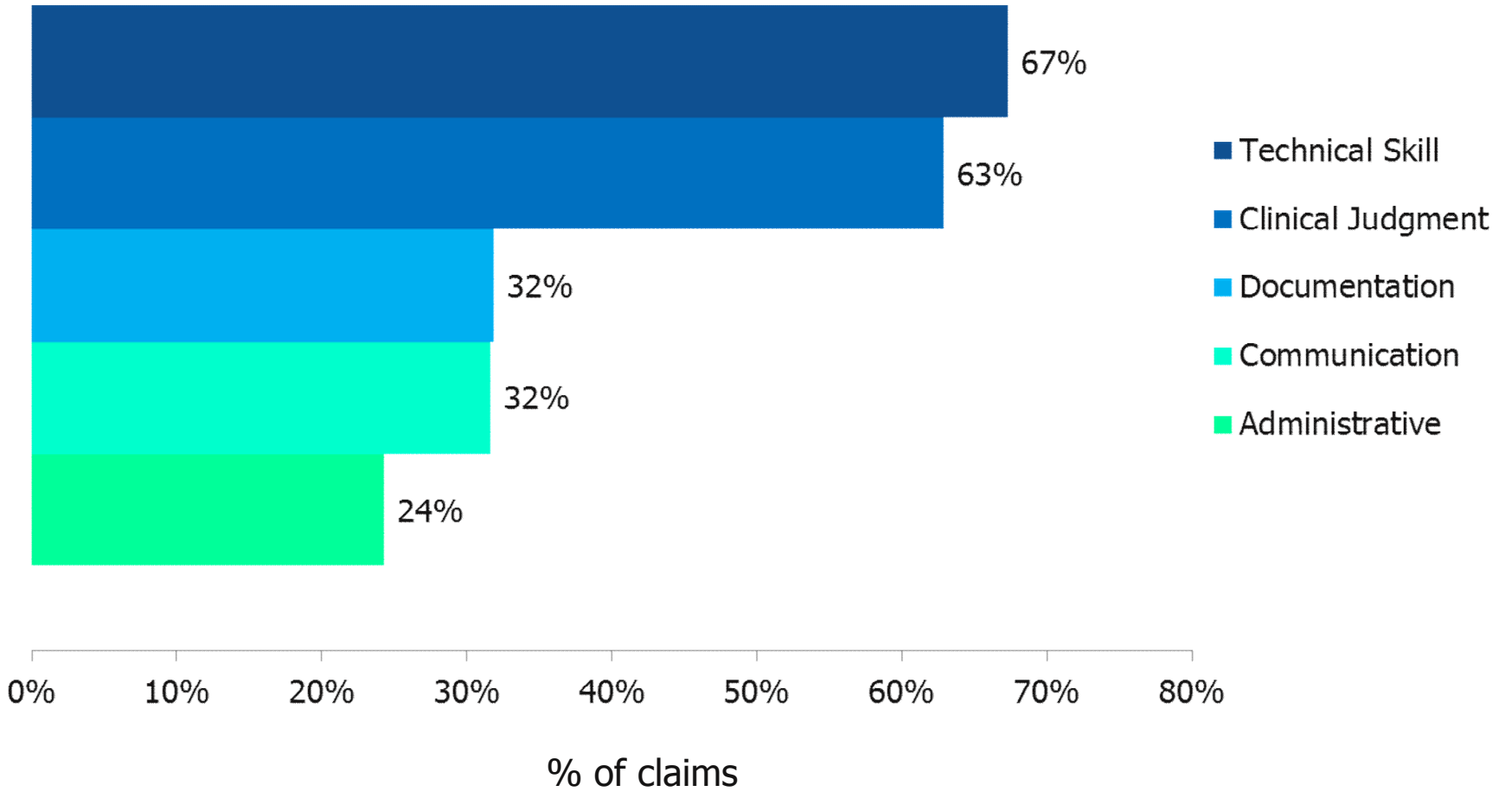


Recurring patient comorbidities are observed across all anesthesia-related treatment claims, with obesity and hypertension topping the list. *(NOTE: More than one comorbidity may be coded per claim.)*

Additionally, obesity and hypertension together account for almost 50 percent of total incurred dollars. *(NOTE: Total incurred dollars = expense + indemnity paid on closed claims and reserved on open claims)*.

MedPro Group claims data, 2004-2013 (anesthesiology as responsible service)

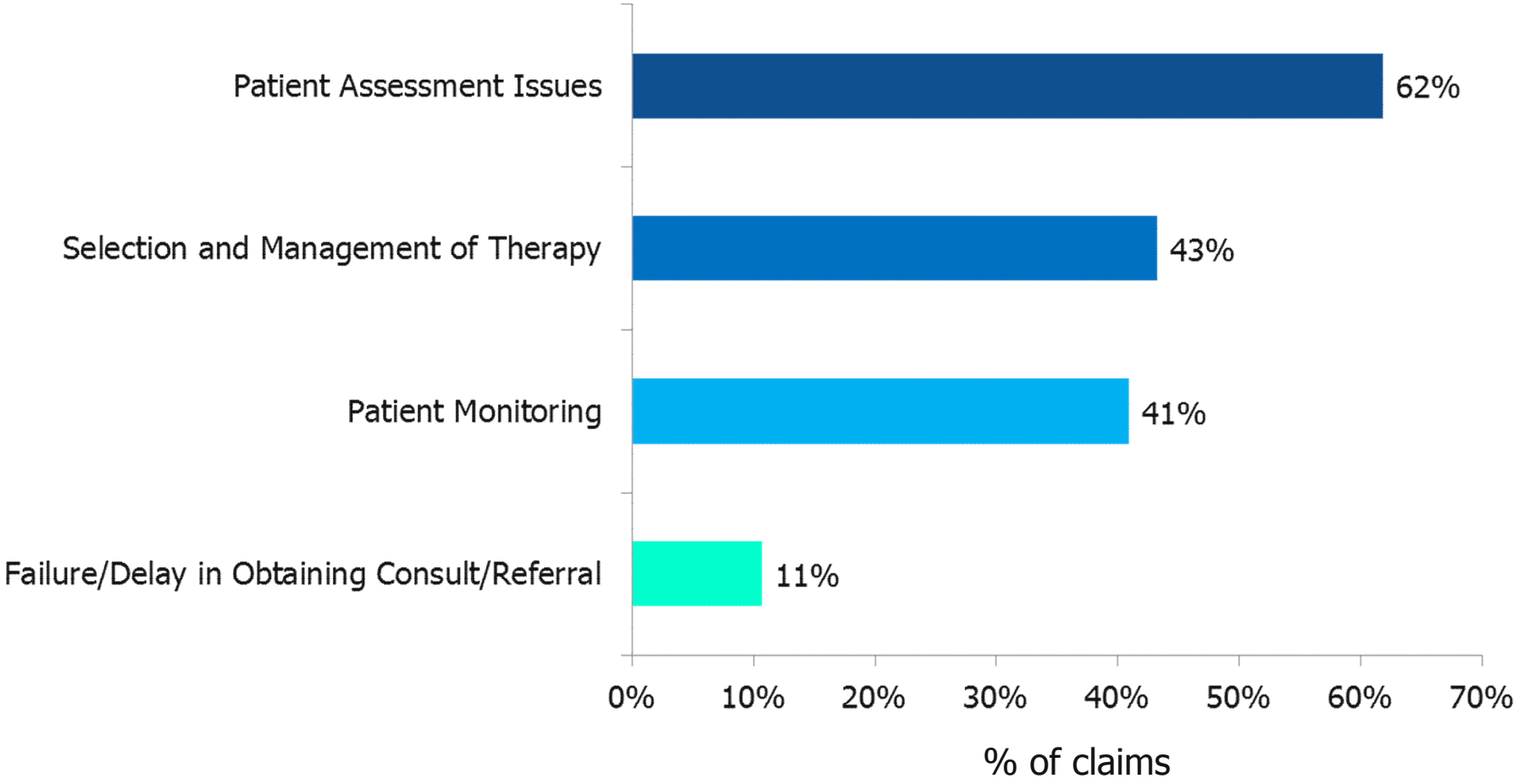
Anesthesia-related treatment: top contributing factors



Contributing factors are broad areas of concern that may have contributed to allegations, injuries, or initiation of claims. These factors reflect issues that may be amenable to loss-prevention strategies. *(NOTE: A claim may have one or more contributing factors.)*

MedPro Group claims data, 2004-2013 (anesthesiology as responsible service)

Anesthesia-related treatment: focus on clinical judgment



Clinical judgment issues represent the cognitive decisions made during provider assessment of patients.

MedPro Group claims data, 2004-2013 (anesthesiology as responsible service)

Obstructive sleep apnea

OSA and medical liability

Med Mal Case Settles for $6.2M

9-year-old boy suffered extensive and permanent brain damage after an August 2005 surgery to remove his tonsils and adenoids.

$9.1M awarded to family of 17-year-old boy who died following elective tonsillectomy for treatment of OSA.

Patient was given morphine in PACU that required reversal with naloxone injection. Following dose of naloxone, he was transferred to ward, where his monitors were turned off and the door shut to let him sleep off the effects of the drug. He died of respiratory arrest.

$7M Settlement for Anoxic Encephalopathy

45-year-old male patient underwent abdominal surgery. During the postoperative period he exhibited signs and symptoms of sleep apnea with abnormalities in his heart rhythm. He was transferred from the PACU to an unmonitored medical floor without an EKG monitor, pulse oximetry monitoring, or continuous blood pressure monitoring. Less than four hours later he was found in cardiopulmonary arrest, and has suffered severe and permanent brain damage.

Obstructive sleep apnea

"Death or neurologic injury after tonsillectomy in children with a focus on obstructive sleep apnea: **Houston, we have a problem**!"

Cote, C. J., Posner, K. L, & Domino, K. B. (2014, June). *Anesthesia and Analgesia, 118*(6), 1276-1283. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23842193

- Death and permanent neurologic injury occurred in 77 percent of cases; were reported in the OR, PACU, inpatient, at home.
- 57 percent of children fulfilled American Society of Anesthesiologists (ASA) criteria to be at risk for OSA.

Obstructive sleep apnea

Do the facilities in which you practice have an organizational approach to OSA?

Are OSA clinical indicators assessed for all patients receiving anesthesia or spinal/ epidural opioids?

Do patients who have OSA or are at risk for OSA have increased levels of monitoring?

Risk mitigation: STOP-Bang

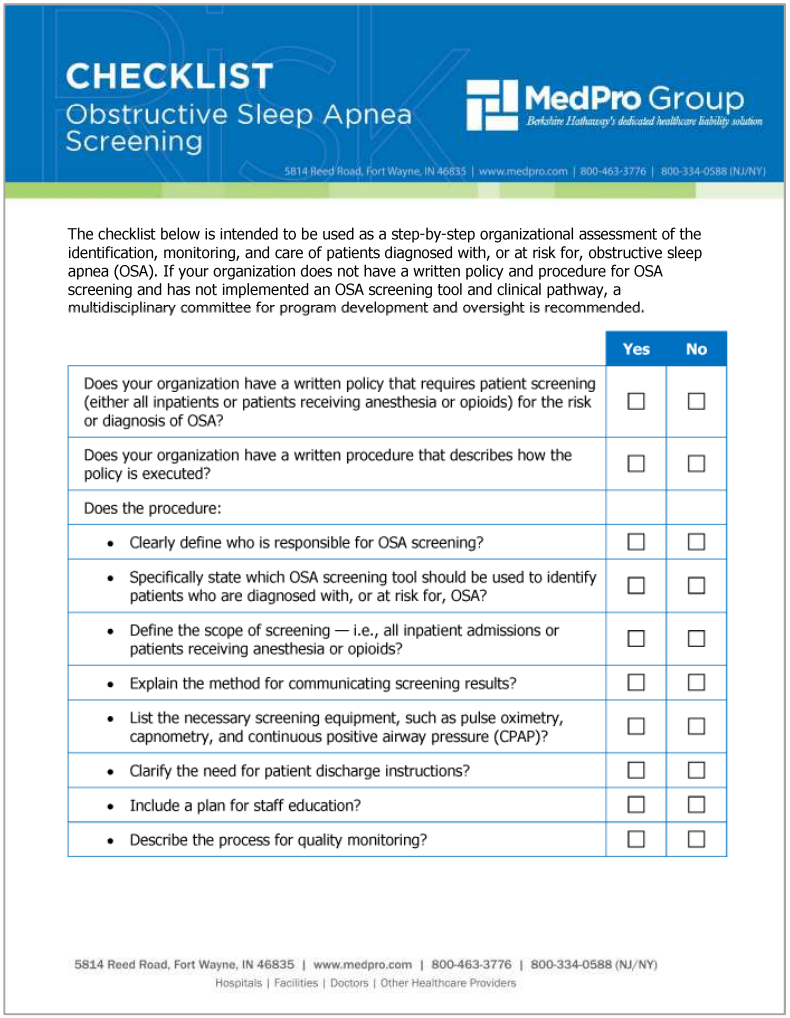
Clinical Characteristics

- **S**noring
- **T**iredness
- **O**bserved apnea
- **P**ressure (hypertension)
- **B**MI >30
- **A**ge >50
- **N**eck circumference >40 cm
- **G**ender male

Screening

- Three or more: at risk for OSA
- Sensitivity: 93 percent

Risk management strategies



CHECKLIST
Obstructive Sleep Apnea Screening

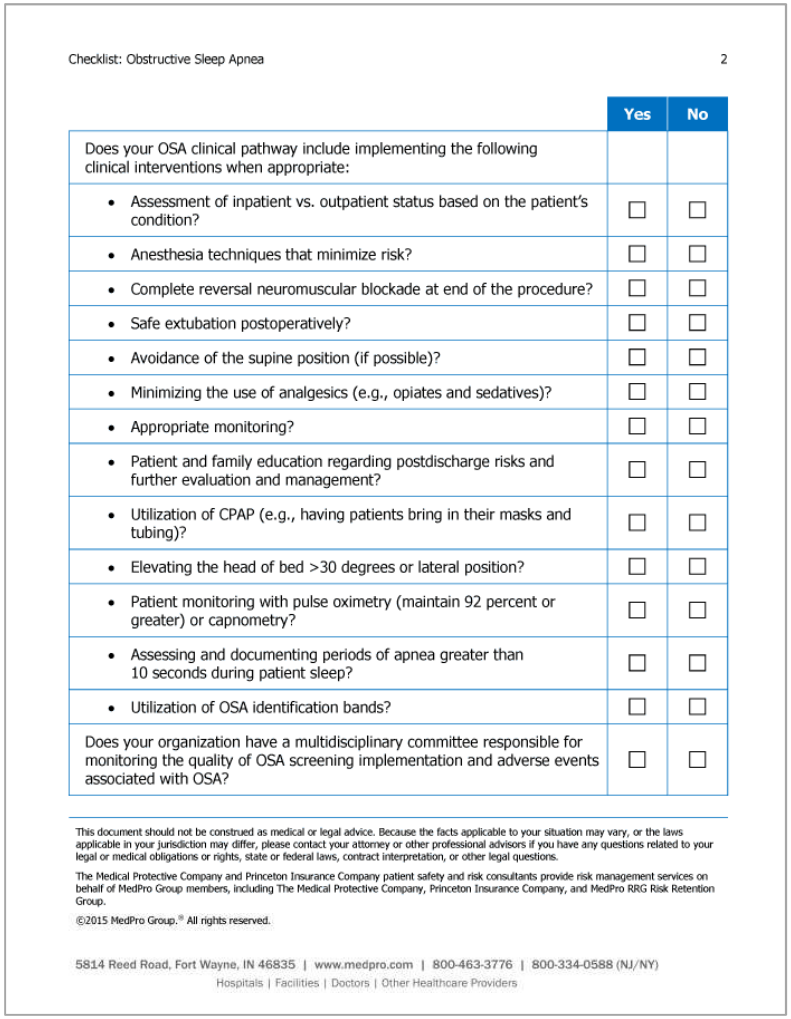
MedPro Group
Berkshire Hathaway's dedicated healthcare liability solution

5814 Reed Road, Fort Wayne, IN 46835 | www.medpro.com | 800-463-3776 | 800-334-0588 (NJ/NY)

The checklist below is intended to be used as a step-by-step organizational assessment of the identification, monitoring, and care of patients diagnosed with, or at risk for, obstructive sleep apnea (OSA). If your organization does not have a written policy and procedure for OSA screening and has not implemented an OSA screening tool and clinical pathway, a multidisciplinary committee for program development and oversight is recommended.

	Yes	No
Does your organization have a written policy that requires patient screening (either all inpatients or patients receiving anesthesia or opioids) for the risk or diagnosis of OSA?	☐	☐
Does your organization have a written procedure that describes how the policy is executed?	☐	☐
Does the procedure:		
• Clearly define who is responsible for OSA screening?	☐	☐
• Specifically state which OSA screening tool should be used to identify patients who are diagnosed with, or at risk for, OSA?	☐	☐
• Define the scope of screening — i.e., all inpatient admissions or patients receiving anesthesia or opioids?	☐	☐
• Explain the method for communicating screening results?	☐	☐
• List the necessary screening equipment, such as pulse oximetry, capnometry, and continuous positive airway pressure (CPAP)?	☐	☐
• Clarify the need for patient discharge instructions?	☐	☐
• Include a plan for staff education?	☐	☐
• Describe the process for quality monitoring?	☐	☐

5814 Reed Road, Fort Wayne, IN 46835 | www.medpro.com | 800-463-3776 | 800-334-0588 (NJ/NY)
Hospitals | Facilities | Doctors | Other Healthcare Providers



	Yes	No
Does your OSA clinical pathway include implementing the following clinical interventions when appropriate:		
• Assessment of inpatient vs. outpatient status based on the patient's condition?	☐	☐
• Anesthesia techniques that minimize risk?	☐	☐
• Complete reversal neuromuscular blockade at end of the procedure?	☐	☐
• Safe extubation postoperatively?	☐	☐
• Avoidance of the supine position (if possible)?	☐	☐
• Minimizing the use of analgesics (e.g., opiates and sedatives)?	☐	☐
• Appropriate monitoring?	☐	☐
• Patient and family education regarding postdischarge risks and further evaluation and management?	☐	☐
• Utilization of CPAP (e.g., having patients bring in their masks and tubing)?	☐	☐
• Elevating the head of bed >30 degrees or lateral position?	☐	☐
• Patient monitoring with pulse oximetry (maintain 92 percent or greater) or capnometry?	☐	☐
• Assessing and documenting periods of apnea greater than 10 seconds during patient sleep?	☐	☐
• Utilization of OSA identification bands?	☐	☐
Does your organization have a multidisciplinary committee responsible for monitoring the quality of OSA screening implementation and adverse events associated with OSA?	☐	☐

5814 Reed Road, Fort Wayne, IN 46835 | www.medpro.com | 800-463-3776 | 800-334-0588 (NJ/NY)
Hospitals | Facilities | Doctors | Other Healthcare Providers

http://www.medpro.com/rm-checklists

Obstructive sleep apnea: case study

Standard of care

Standard of care: "In law of negligence, that degree of care which a reasonably prudent person should exercise under same or similar circumstances."

— Black's Law Dictionary

Obstructive sleep apnea: case details

4-year-old child: tonsillectomy and adenoidectomy in surgery center

History of OSA

Phase 1 PACU: brief period of desaturation postextubation

Dr. A: verbal order to hold Lortab®

At 9:35, Phase 1 nurse: "PO pain med held due to sleepiness"

At 10:13, Phase 2 nurse: "Gave Lortab and notified Dr. B"

At 10:30: Dr. B discharged patient; note in chart: "patient carried by father to car"

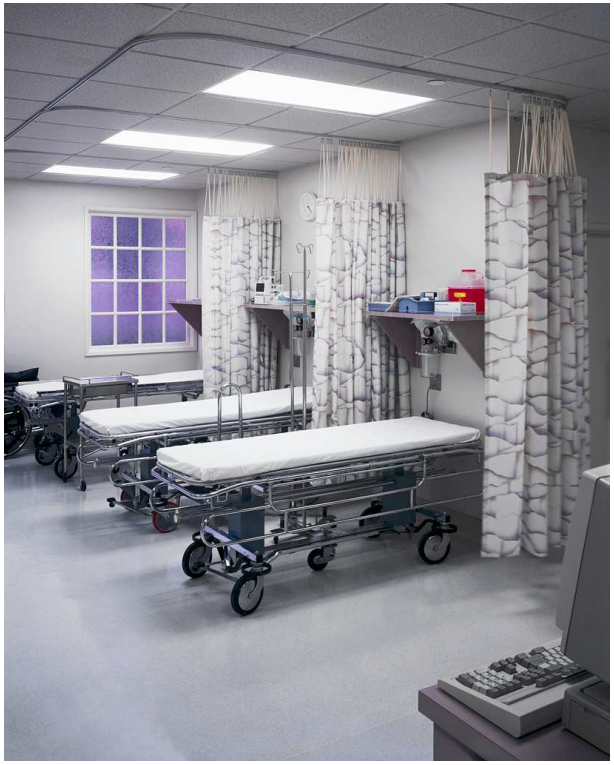
At 13:30: Surgeon notified patient in ED . . . brain dead

Obstructive sleep apnea: case challenges

- Preoperative history provided by father
- Mother described symptoms of severe OSA and history of asthma — but not until deposition
- Parents reported child was very sleepy after Lortab administration
- Parents reported doctor was notified that the child was given Lortab before discharge
- Expert testimony

Obstructive sleep apnea: medical and legal issues

- Appropriate clinical setting?
- Adequate medical history?
- Appropriate patient disposition?
- Communication:
  - Handoffs
  - Verbal Lortab order: discontinue or hold?
  - Dr. B denies notification of sleepiness
- Knowledge deficit: OSA and opioids



Informed consent

Impact of informed consent

"Effectively engaging patients in their own health care through the informed consent process may be one of the most practical steps in reducing the likelihood of litigation."

— Steven R. Stanford, JD

ASA Newsletter, July 2006

Informed consent essentials

- Patient name
- Procedure name (both in medical and layman's terms)
- Description of the procedure
- Risks and benefits of the proposed treatment or procedure
- Treatment alternatives, including doing nothing
- Patient signature memorializing understanding and providing consent
- Witness signature

Informed consent in litigation

- Plaintiff attorneys use allegations of inadequate informed consent as a tactic to undermine confidence in the anesthesia care.
- Poorly documented informed consent could lead to allegations of:
    - Provider failure to appreciate significant risks and to develop appropriate plan of care.
    - Provider exhibited paternalistic behavior.
    - Provider unwillingness to engage with the patient in a meaningful discussion regarding anesthesia.

Stanford, S. R. (2006). Informed consent: The Verdict is in. *ASA Newsletter.* Retrieved from http://www.asahq.org/resources/publications/newsletter-articles/2006/july2006/informed-consent-the-verdict-is-in

Approaches to informed consent

Handwritten notes

- Detailed notes of discussion with patient, or rely on "usual and customary" practice

Hospital or surgical consent

- Hospital's focus usually is on decreasing risk to hospital
- Anesthesia is secondary focus at best; usually very brief

Anesthesia consent forms

- Specific to anesthesia
- Identify significant risks and choices; modify as needed for specific patient issues
- Provide record of conversation with the patient

Remember

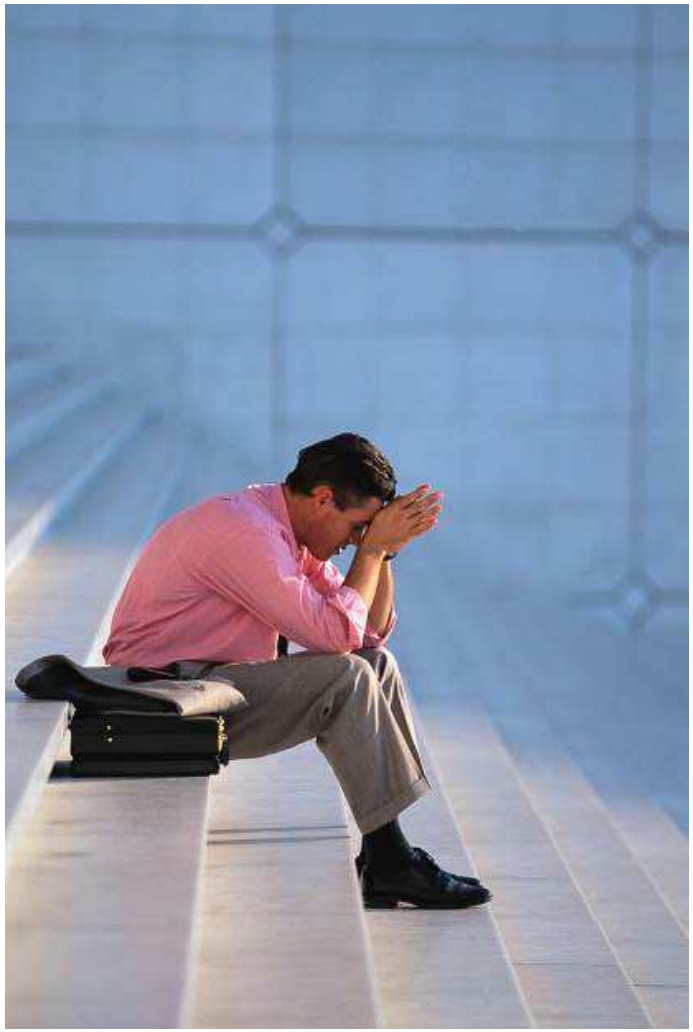
- Informed consent is a nondelegable duty of the physician.
- A signed form may not equal an informed consent.
- A signed consent works best when it documents the discussion between a physician and a patient.

Documentation

Documentation: electronic health record risk factors

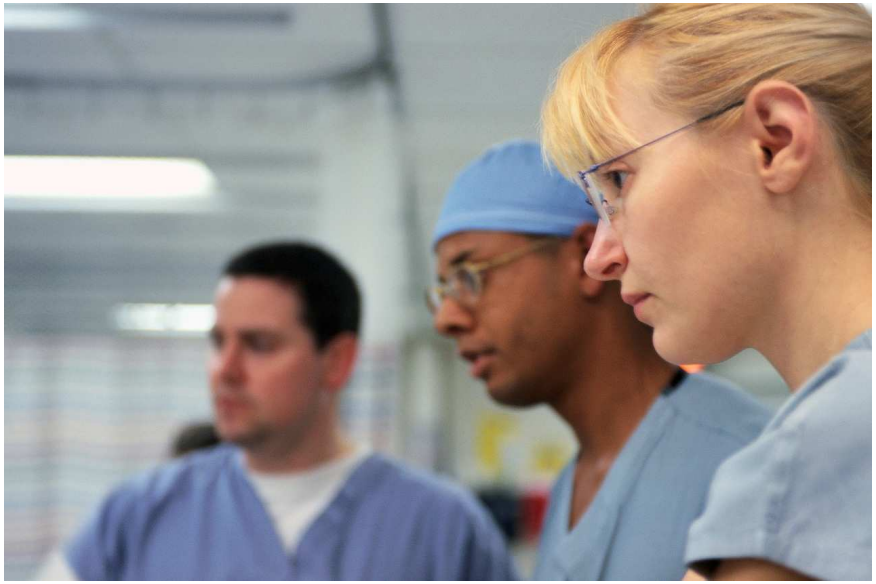
- System functionality
- User training and competency
- System flexibility to avoid "workarounds"
- Lack of time synchronization
- Prefilled templates
- Disabling reminders/alerts
- Authentication/ verification requirements
- Ability to network with other systems
- Missing data

Disclosure



Challenges for providers

- Knowledge of organization's disclosure policy
  - What is the definition of unanticipated outcome, adverse event, and medical error?
  - What is the process for disclosure?
  - Who should be involved?



Risk mitigation — understand your responsibilities

- Review the facts of the incident.
- Focus on next steps in caring for the patient (don't avoid the patient or family).
- Empathize/sympathize.
- Collaborate with other physicians/staff.
- Work with administration/risk management to coordinate communication and follow-up.
- Apologize, if appropriate — know your state's apology laws.
- Know your state's reporting requirements.
- Communicate and document the facts only — don't hypothesize (verbally or in the chart).
- Don't blame others.
- Coordinate services, write-offs, or charges in conjunction with the facility and liability carrier.
- Don't promise "we will take care of everything."

Disclosure vs. admission of liability

Understanding the Difference

- **Disclosure and apology:** I'm sorry Mrs. Jones, but your child became unresponsive and stopped breathing during the procedure and we had to resuscitate her. She is doing fine now, and we are going to closely watch her for the next several hours.
- **Admission of liability:** I'm sorry Mrs. Smith that your child became unresponsive during the procedure. I may have given her too much medicine.

Is honesty always the best policy?

- Remember: The facts should be documented in the medical record, so error may be discovered later.
- What is the risk of *not* disclosing?
  - What are the consequences of late discovery?
  - What are the perceptions related to perceived cover up?

Communication checklist

Who should participate?

- Attending physician or independently licensed practitioner. (Decide who will be the primary spokesperson.)
- A representative from the hospital, who is perceived as being an authority.
- Patient and family. (Consider desires of patient and HIPAA Privacy Rule.)
- Translator, as appropriate.

Communication checklist

When?

- As soon as practical following the event
- As soon as basic facts are known
- As soon as the patient and/or family is able to receive the message

Communication checklist

Where?

- A quiet room that provides privacy
- Where interruptions can be kept at a minimum

Communication checklist

What?

- Provide simple, concise facts in plain language.
- Obtain feedback throughout the discussion.
- Commit that further meetings with the patient/family will be arranged when more information about the event is known.

Communication checklist

What?

- Discuss current medical status of the patient and anticipated treatment.
- Explain how recurrences will be prevented (when known).
- Offer an apology.

Communication checklist

Apology

- **Unanticipated outcome:** "I am sorry. I did not expect this to happen."
- **Medical error:** "I am sorry that this has happened."

Communication checklist

Describe next steps

(in the event of a medical error)

- "We are reviewing this situation to determine how this occurred and what can be done to prevent this from happening again."
- Provide the name and phone number of the practice or hospital representative who will contact the patient or designated family member.
- Establish timely date for follow-up.
- Offer to be available for future questions.

Communication checklist

Empathy

- Identify the emotion(s) observed in the patient and/or family.
- "This must be very frightening (upsetting, scary, overwhelming, sad, angry, difficult, etc.) for you."

Communication checklist

Tips

- Establish direct eye contact.
- Sitting is preferred.
- Use “I” instead of “we.”
- Speak slowly and use plain language.
- Be brief.
- Anticipate questions.
- Be prepared for patient/family confusion or anger.
- Stop frequently, ask whether the patient/family has questions.

Communication checklist

Tips

- Avoid saying “I know how you feel; this is a blessing in disguise; these things just happen.”
- Do not point fingers.
- Do not avoid the patient/family in hopes of avoiding questions.

Communication checklist

Don’t forget

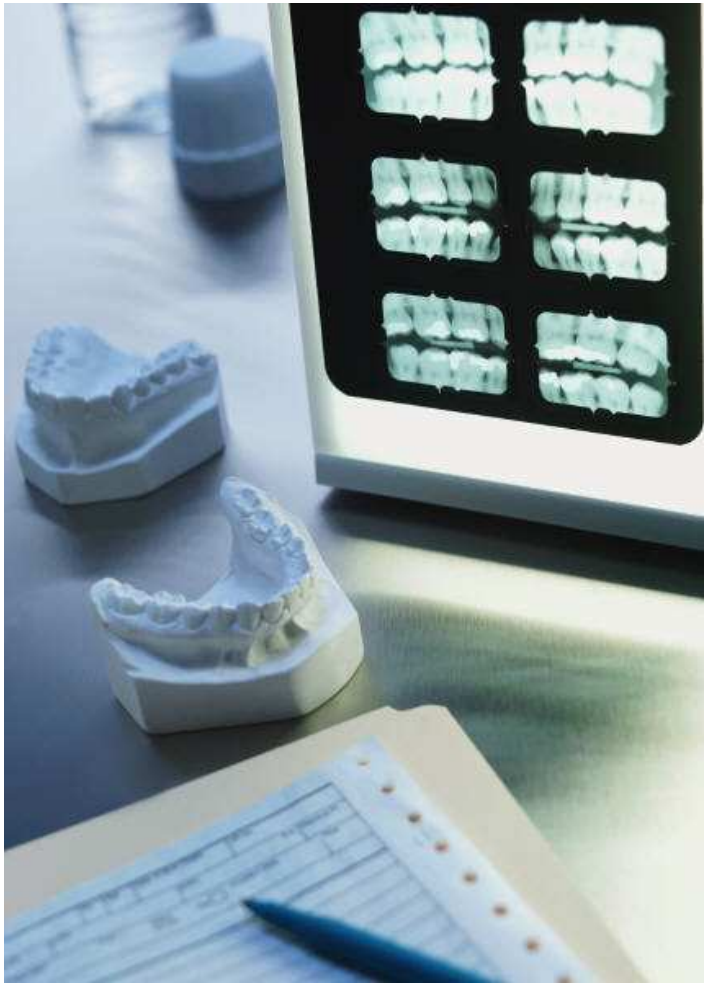
- Staff involved in the medical error may require support counseling.
- Document communication: who was present, factual description provided, plan of care.
- Stop patient billing until the details of the medical error are analyzed.

Communication checklist

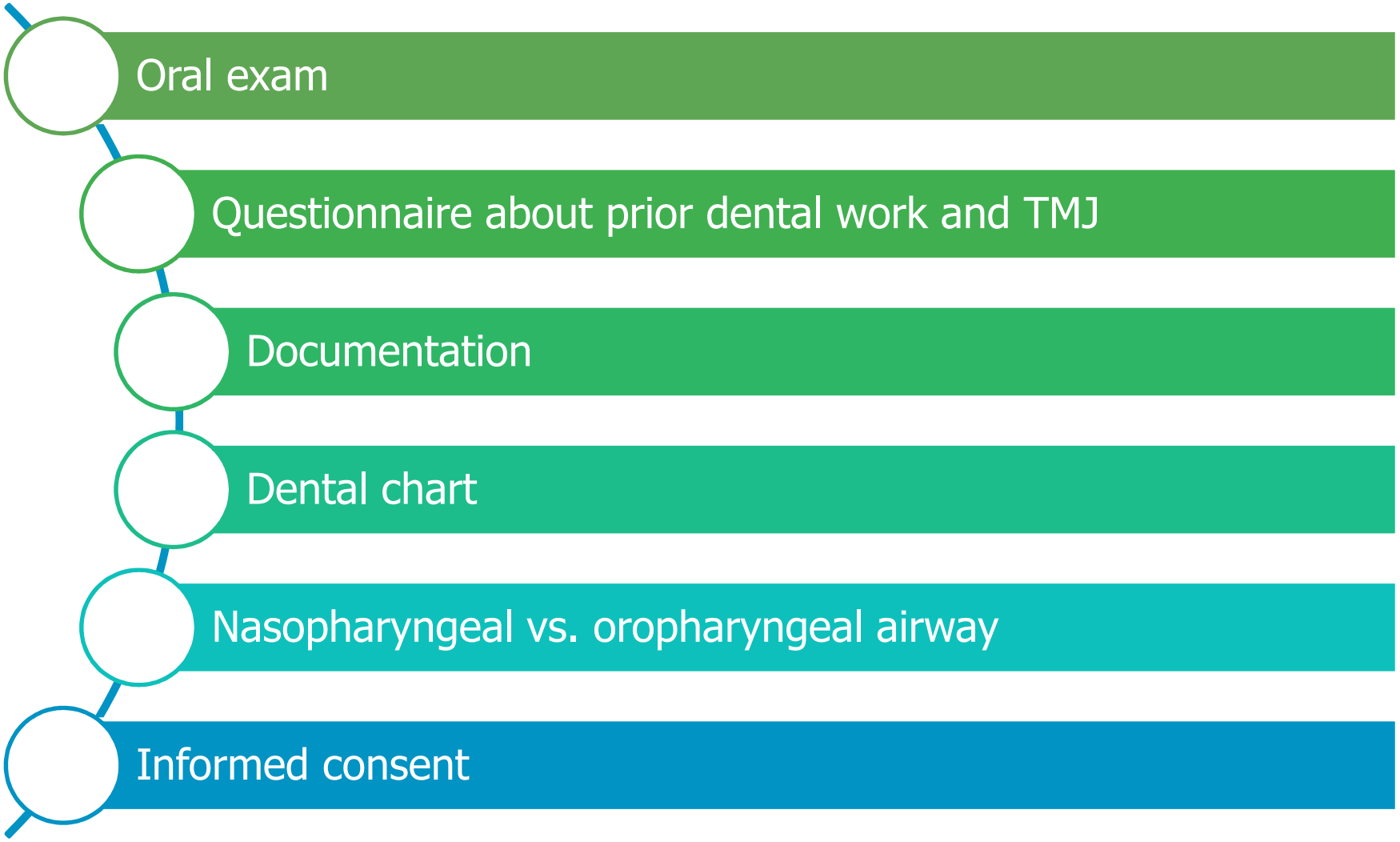
Don’t forget

- Consult with your claims or insurance staff when early resolution is indicated (as it relates to a medical error with damages).
- A discussion of monetary settlement is not recommended at the first meeting with the patient and/or family.

Avoiding and managing dental claims



Risk management strategies: preoperative measures



Risk management strategies: postoperative measures

Document any complaints and examine.

Follow-up plan and philosophy:

- Do you want to reimburse? When?
- Evaluation and estimate by dentist.
- Discussion and agreement with patient.
- Release.
- Understand reportable vs. nonreportable payments.

Refunds and waivers

Refund and waiver options, considerations

- Options:
  - Deny the request for a refund or waiver.
  - Refund/waive the full amount paid.
  - Refund/waive a portion of the amount paid.

- Considerations:
  - A refund/waiver can be effective in diffusing patient dissatisfaction; it is not an admission of liability.
  - Notify patient in writing of decision.
  - Seek release from liability (if appropriate).
  - Medicare patients — special considerations apply for "professional courtesy discounts" (other than for financial hardship).
  - Consult your professional liability carrier and/or legal counsel for specific advice.

Critical points safety checklist

Preoperative

- Discuss/document anesthesia risks, benefits, alternatives with the patient (obesity is specific risk factor to consider).
- Review patient's complete medical record.
- Conduct OSA screening.
- Verbally communicate and document any preoperative adverse findings with the anesthesiologist/CRNA responsible for anesthesia induction.
- Be aware of hospital/ambulatory surgery policies affecting provision of anesthesia services.

Critical points safety checklist

Intraoperative

- Participate in an OR timeout prior to all surgeries; discuss anesthesia plan.
- Have an anesthesiologist or CRNA remains in the OR at all times with the patient.

Intubation

- Verify and document correct initial placement and placement after patient is transferred.

Postoperative

- Have a member of the anesthesia team remain in-house while patient is recovering from anesthesia.
- Review documentation (accurate, complete, chronological, legible, professional).

In summary

Best practices	Create and comply with assessment to discharge processes.
OSA	Ensure an organized program is in place to screen for and manage condition.
Informed consent	Document communication and formalize with an informed consent tool.
Adverse event management	Develop disclosure guidelines, including care for “second victims.”