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PROTECTOR

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Osteopathic physicians, non-physician doctors, and advanced practice healthcare professionals can submit certificates to their professional associations for review. If you pass two tests within one year, you also may be eligible to earn a one-year risk management premium credit which will be applied automatically at your next policy renewal.*

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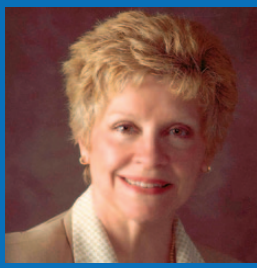

Dear Medical Protective healthcare provider:

This year, *Protector* has focused on risks that occur when healthcare professionals struggle to manage financial challenges, regulatory demands, and their ongoing commitments to patients. In this final issue of the series, we examine conflicts that can occur when decreased revenue and reimbursement throw the patient care process out of whack.

Have you explored new ways to increase revenue – and has patient satisfaction been included in this exploration? Do you feel compelled to cut back on some services? Have you examined all the possible ramifications of this decision? Are you worried about possible staff layoffs? Changing vendors for supplies? Have you asked yourself if these decisions might have unintended results? Are you worried about the additional expenses associated with government mandates when your reimbursement numbers are clearly shrinking? If so, then this issue of *Protector* may be useful. Even if you're not making some of the mistakes we will talk about, colleagues to whom you refer – or from whom you accept referrals – may be on the wrong track – with potential risk implications for you.

By reading these articles, you should be able to:

- Explain why a risk assessment is essential to the search for new revenue;
- Compare and contrast risk *vs.* benefit elements of revenue planning; and
- Devise collaborative strategies that sustain or enhance quality of care while improving the financial outlook.

As a reminder, Medical Protective is accredited to provide Continuing Education (CME or CDE) hours for physicians and dentists. One of the ways to earn CME or CDE credits is by taking a test after reading this issue of *Protector*. Online access will make it easy for you to complete the test that will accompany each issue. MedPro insureds who successfully complete two tests, in the same year, may also earn premium credits. For more information, read the inside cover of this issue of *Protector*. Or, visit our website at www.medpro.com.

Sincerely,

Kathleen M. Roman

Kathleen M. Roman, M.S.
Risk Management Education Leader

Enterprise Risk Mana

Balancing the Equation Between and Plunging Revenue

Kathleen M. Roman, M.S.

Economic dominos

Many Americans, struggling with financial hardships, are unable to afford healthcare. Similarly, many physicians and dentists are finding it difficult to make ends meet in an economic environment in which faithful patients have moved away or must now forego care because they have lost jobs, health insurance, and possibly their homes.

The ripple effect of the economic downturn is compounded by the slashed reduction in healthcare reimbursements. According to the literature, many physicians are earning less today than they did ten years ago.[1, 2] In addition, physicians and dentists alike feel the pressure to see more patients per day in an attempt to compensate for the loss of reimbursement dollars.

While crowding the schedule may seem like a logical approach, there are only so many hours in a working day and, taken to extreme, there is evidence that a cramped schedule hampers staff morale, increases the possibility of error – and resultant patient injury – thus increasing the risk of malpractice allegations.

An interesting occurrence, and the trigger for this article, is the increase in the number of contacts with Medical Protective risk management consultants in which insureds are testing the waters with novel methods to save money and/or to increase revenue and reimbursement. The variety and, in some cases, the dangerous assumptions that are shared during the course of these discussions, make it clear that many doctors are confused about how to best address these economic challenges. Hence, this issue of *Protector* focuses on how extremely important it is to ensure that business strategies don't ignore the foundation of healthcare: first, do no harm.

"There is evidence that a cramped schedule hampers staff morale, increases the possibility of error – and resultant patient injury – thus increasing the risk of malpractice allegations."

While it's a good idea to save money, increase reimbursement, revamp services, and improve efficiency – these dollar-stretching tactics, in a vacuum, may have negative results. Rather, these plans should be subjected to a filter that will identify their potential downside as well as their perceived benefits. (See "Sometimes a Fix Isn't Really A Solution" on page 10 for examples of revenue and reimbursement "strategies" that had negative implications for patient care.)

Surveying the options

If Practice A is making substantially less money than it did five years ago, solutions to this predicament fall into a handful of categories: a) cut back on expenditures; b) introduce new revenue-producing services; c) offer cash-only options; and d) analyze contracts and identify re-negotiation opportunities. From an accounting perspective, any of these options may make sense. But running the numbers is only one part of a feasibility study. Healthcare professionals need better tools to help them see the whole picture.

gement:
Patient Safety

Enterprise risk management

For years, the standard approach to risk management has been avoidance ("No, we don't offer that service.") or transfer ("We have insurance to cover that."). Within the past decade, however, a new type of risk management has become increasingly popular in the business community. Called enterprise risk management (ERM), this comprehensive system uses an organization-wide approach, not just to avoid risk but to incorporate change that provides tangible benefits.

While this is often done on a grand scale by healthcare systems or medical schools, ERM benefits can apply to any office or practice, regardless of size. According to the Casualty Actuarial Society, ERM is "the discipline by which an organization in any industry assesses, controls, exploits, finances, and monitors risks from all sources for the purpose of increasing the organization's short- and long-term value to its stakeholders."[3] The American Society for Healthcare Risk Management uses a slightly different definition. ERM is "a structural analytical process that focuses on identifying and eliminating the financial impact and volatility of a portfolio of risks rather than on avoidance alone. Essential to this approach is an understanding that risk can be managed to gain a competitive advantage."[4]

The next section of this article provides an example of an ERM assessment that was undertaken by a hospital. The case was selected because it offers a not-too-elaborate overview of how the ERM process works. Readers who don't work in hospitals may miss the point if they dismiss this example as not being applicable to their professions. In any clinical environment, from the smallest one-practitioner office to the largest multi-office group, ERM analysis can help ensure that decisions made in one function of the organization don't negatively affect other functions. And, just as important, ERM analysis can help any organization hone in on opportunities it might otherwise have missed. Regardless of the clinical licenses and specialties of the providers, the take-aways are the same: ERM can help healthcare professionals balance the sometimes disparate elements of financial stability and quality patient care.

ERM analysis

This case takes place in Hospital B. It has recently had to defend itself against a lawsuit in which parents of a neurologically-impaired baby allege that their child was harmed by the actions of the labor and delivery team. Because documentation of various aspects of the post-delivery care is sketchy at best and, in several cases, simply absent, it likely will be difficult to mount an adequate defense, and so the hospital makes a substantial settlement offer.

The family accepts the settlement offer and the matter is closed – except that now several members of the leadership team are adamant that they want to avoid this kind of problem in the future. A financial analysis is used to suggest that Hospital B could save a substantial sum by closing its obstetrics (OB) department. After all, an OB department, along with its nursery and requirements for a highly-trained nursing staff, are extremely expensive and, in addition, this service has always generated significant liability exposures.

From a strictly risk averse perspective, closing the OB department might make sense – unless one uses an ERM approach to identify, not just the already-noted risks associated with obstetric services – but also the unique benefits that an OB department brings to a hospital (the enterprise).

First, an OB department brings in a steady revenue stream. True, it is an expensive department to operate but, if the hospital assesses how many first-time moms return for the delivery of their future babies, one delivery is likely to generate return business in a way that a hysterectomy will not.

Second, of those families whose children are born in this hospital, how many of them go on to associate with pediatricians and family physicians who are affiliated with the hospital? Here's an additional benefit to the hospital's bottom line – another self-perpetuating referral base.

Third, in the event that someone in one of these families becomes ill, their previous positive experience with the hospital increases the odds that they will accept referrals from their primary care doctors to specialists within the hospital's network.

Fourth, because the arrival of a baby is typically a joyous event, the hospital that can provide a satisfactory delivery experience earns an ongoing surplus of goodwill, which spreads by word of mouth beyond the family to friends, neighbors, and work associates.

An OB department allows for public relations interactions with the rest of the community. Friends and family members may visit the hospital before mom and baby are discharged. Through this social activity, the hospital has yet another opportunity to "seed" goodwill into the community.

The hospital's client feedback data can be used to determine how patients made choices about providers, referrals, and the hospital itself. Using their referral surveys, customer satisfaction data, and other information, Hospital B can estimate the additional income it receives because patients and family members had a positive interaction with their OB service. This same data will also prove useful in negotiating managed care contracts, grant applications, and formation of an Accountable Care Organization (ACO).

In addition, Hospital B may discover that a significant percentage of the gifts, flowers, and toys sold in its gift shop are headed for the OB floor. Because many of these funds are plowed back into the community through charitable activities, the hospital benefits from yet another positive influence in its service area.

If they've obtained sufficient data, the hospital might be able to analyze information about their long-term donors to determine if/to what extent staunch financial supporters were positively influenced by an interaction with the OB service.

Additionally, they will also want to take into account public perception reports that hospitals without OB departments (and Emergency Departments, as well) are perceived as less involved in the communities they serve than hospitals that offer these services.

In the end, a decision to eliminate OB services cannot be made without taking

into account the benefits that are likely to disappear as well. It is important to determine the financial value of each element before determining the "savings" that the elimination of the OB department might be expected to produce.

ERM in a smaller environment

The need to increase revenue and reimbursements can cause a lot of stress in a medical or dental practice. Using the multiple perspectives of an ERM assessment, doctors can estimate the financial implications of strategic planning and also assess their impact on patient safety and satisfaction, staff morale, and the organization's reputation in the community. One medical practice administrator said, "We used ERM to see if our financial decisions would affect our ability to live up to our Mission Statement."

The sample ERM chart (pages 8-9) lists eight key domains that healthcare providers can use as filters for their action plans. Here's an example. The ABC Practice is looking for ways to improve its reimbursement efficiency. They've set up a team which proposed and evaluated several options. Right now, the key contender is to hire a new staff person who can improve the accuracy and speed of their insurance reimbursement submissions.

The sample ERM domains offer a series of factors that might reveal risks and/or opportunities for the proposed new hire. The eight sample domains are typically static but can be changed. For example, some organizations use just three domains: a) people; b) finances; and c) operations.

The sub-categories should be reviewed since some of them may be irrelevant to certain groups or practices. Also, depending on the professional services provided, the group or practice might want to add sub-categories that are especially important to their success. Any group utilizing an ERM approach will want to make sure that the sub-categories have been customized to fit their organization. A review of each factor should include the following questions:

a) Is there a potential downside to the proposal's interaction with sub-categories of each domain?

b) Can we identify possible opportunities or advantages that we haven't previously thought of that might make this proposal even more beneficial?

For example, a review of the Clinical Care domain might reveal that a new coder will need some practice-specific education and interaction with scheduling staff so that they are all on the same page when identifying the purpose – and thus, correct codes – for patients' appointments. A coder might also need to be educated about the practice's participation in national specialty associations that provide guidelines about a standard of care or about professional ethics. Will this cost money at the forefront? Yes. Will it save money by preventing miscoding and delays in reimbursement? Yes.

With regards to the Financial Management domain, the new employee will require competency oversight for all three sub-categories. It won't do the practice any good to hire someone who has the technical skill but has no clue about the specialty services being offered by the practice. Taking this minimum list into account, each medical or dental practice might want to add additional items specific to their own processes.

A cost should be assigned to the recruiting, hiring, and training for this individual. It may be dangerous to turn a new employee loose without first providing adequate credentialing, training, and mentoring (oversight and support). A comprehensive "onboarding" program should be ensured through the Human Capital domain and the costs for enacting these steps should be part of the Financial Management domain.

Thinking of changing your purchasing arrangement for implements, materials, or supplies? Use the ERM template to answer the following questions:

1. Have we checked to see that a change in vendors/supplies will not deteriorate the quality and durability of materials/ supplies we are currently using?
2. Will any changes in equipment or supplies increase the potential for employee/ patient injury?
3. Have we investigated to ensure that a new pricing arrangement isn't just a "gimme" with substantial rate increases incurred after a contract has been signed?
4. If the new arrangement is an online source, do we know how to manage the state's sales tax? (In these revenue-seeking days, some states are becoming very aggressive about this.)

These are just a few questions that the template will help the thoughtful practice leader identify and address.

At the end of the assessment process, ABC Practice may indeed decide that they want to hire a new coder. In addition, they may have identified other benefits that this employee can bring to the group, e.g., cross training, improved internal audits, significant reduction in flawed submissions, etc. The point is, they won't be guessing that this is a good idea. They'll know.

On the other hand, having worked their way through the various domains, they may decide to invest in staff education that will improve how their doctors and staff document appointments and procedures and improve the accuracy of their current coding team's filing processes. This approach might highlight the fact that some member(s) of the team are much more productive than others. Hard data provides leverage to encourage performance improvement.

So, another benefit of an ERM assessment is that it may point out that the group doesn't need more employees – it needs to ensure that the existing staff members do their jobs correctly. Performance improvement activities may help eliminate the expenses associated with recruiting, credentialing, and training a new employee. They may also produce savings by eliminating the salaries and benefits of employees whose performance doesn't improve and who can be justifiably terminated from employment.

Either option is plausible. The ABC Practice won't know which plan to pursue until they've worked their way through the template. Any proposed plan for increasing revenue and reducing expenses should be assessed using the ERM. Each practice should feel free to add domains or sub-categories as necessary to help them get the clearest picture, as the domains and sub-categories in this template are just suggestions.

Remember the practice manager who said the ERM is a good tool for measuring a practice's ability to live up to its mission statement? Will the practice save money – without hampering patient care? Will the practice increase revenue – without pushing its employees into a state of exhaustion? Will the practice enact changes that have been adequately assessed and planned – thus preventing possible negative consequences down the road? That's probably the most comprehensive picture that the ERM can provide. ■

FOOTNOTES

1. Staiger, D. O., Auerbach, D. I., and Buerhaus, P. I., Trends in the Work Hours of Physicians in the U.S. *JAMA*, 2010; 303(8):735;747.
2. Tu, H. T., Ginsburg, P. B., Losing Ground: Physician Income, 1995-2003. As quoted by Center for Studying Health Change. June 12, 2006.
3. Enterprise Risk Management. Casualty Actuarial Society. Enterprise Risk Management Committee. 2003. http://www.casact.org/research/erm/overview.pdf
4. Enterprise Risk Management. Monograph. American Society for Healthcare Risk Management. January 2006. p. 1. http://www.ashrm.org/ashrm/education/development/monographs/ERMmonograph.pdf

Do You Know Your Risk Management Consultant?

Each year, Medical Protective risk management consultants receive thousands of phone calls from our insureds. The calls range from routine topics about how long to keep records to urgent concerns such as difficult conversations with angry patients.

As a Medical Protective insured, you are entitled to this free telephone consult service. Many times our clients tell us how glad they are that they called; they feel better just knowing that they have someone on their side who can give them sound advice – and help reduce some of the stress associated with many risk management challenges.

Not certain who your risk management consultant is? Not certain how to get in touch?

a) Login to **www.MedPro.com** and click on "Find Your Risk Consultant" on the left-hand side toolbar. Then enter your state and click "go."

b) Call the Medical Protective home office at: **800-463-3776** and ask the Customer Service team for your consultant's name and contact information.

You may find it helpful to keep this contact information readily available, along with your MedPro policy number. Then, in the event of a problem, your consultant is only a click or a phone call away!

"Many times our clients tell us how glad they are that they called; they feel better just knowing that they have someone on their side who can give them sound advice."

Enterprise Risk Management Template

Clinical Care	Financial Management	Hazard Preparedness	Human Capital
Process Consistency	**Liability Exposures**	**Natural Disasters**	**Just Culture**
Policies & Procedures: • Internal audits and checks • Staff education • Evidence-based practice • Current standard of care • Peer review	• Healthcare-acquired conditions • Insurance coverages • Disciplinary actions, fines	• Storms • Earthquakes	• Culture of safety • Professionalism • Personal accountability • Team building • Employee safety
Evolving Standard of Care	**Reimbursement**	**Environmental**	**HR Structure**
• National Patient Safety Foundation and others • Evolving standard of care • Code of Ethics	• Billing & coding standards • ICD-11 preparation • Dental CDT Codes	• Water damage • Fire	• Policies & Procedures • Employee handbook • Job descriptions • Personal accountability • Team building • Staff meetings
Measurement	**Business Transparency**	**Law Enforcement**	**Competencies**
• Patient safety • Quality/Performance Improvement • Patient complaint resolution	• Corporate compliance • Corporate integrity	• Violence • Crime • Vandalism	• Scope of practice • Licensure/credentialing • Recruiting/hiring process • Training, mentoring, dispute resolution • Reinforcement
	Financial Resources	**Biohazards**	**Conduct**
	• Capital • Prioritization • Integration	• Terrorism • Waste disposal and management	• Discipline/discharge • Disruptive behavior • Sexual harassment • Violence • Criminal activity

Legal & Regulatory	Operations	Strategic Planning	Technology
Provider Integrity and Competence	**Process Consistency**	**Structure**	**Planning**
• NPDB • Licensure • Scope of practice • State Boards • Disciplinary actions • Loss of privileges/specialty designation	• Policies & Procedures • Documentation • Data analysis • Accuracy validation • Billing & clinical notes • Professional liabilty claims	• Acquisitions • Sales, mergers, closures • Partnership dissolution • Retirement • Partner's/owner's death or incapacity • Insurance	• Adequacy/sufficiency • Education • Team - Competence - Commitment - Consistency
Employee Safety	**Compensation Management**	**Service Area**	**Oversight**
• OSHA • Safety oversight • Employee complaints	• Pay4Performance • ACO planning • Validity of care decisions • Compensation	• New service/ elimination of service • Marketplace analysis • Alliances, agreements • Partnerships/affiliations	• Environmental scan • Innovations • Possible effects on standard of care • Process change - Simulation - Telehealth, etc.
Patient Rights	**Outcomes Consistency**	**Regulatory Analysis and Response Planning**	**Safety**
• HIPAA	• Healthcare-acquired conditions • National Quality Forum	• Managed care • Antitrust • Medical/dental "home" • ACO influence	• Use parameters • Training • Preventive maintenance • Vendor relations process and accountability
CMS	**Service Recovery**	**Community Relations**	
• RACs • Other types of government oversight	• Customer satisfaction - Survey feedback • Adverse event management • Disclosure	• Media relations • Crisis management • Community outreach/ education • Volunteerism	
FDA		**Marketplace**	
• Approval • Off-label use • Black box warnings • Withdrawal from market • Research: IRBs and consent		• Marketing plan • Advertising that alters the standard of care - "Guarantees" - "Fraudulent promises"	

Sometimes a "
Isn't Really a

Kathleen M. Roman, M.S. *Note: The author gratefully acknowledges the shared*
risk management consultants MaryAnn Digman, Gail Harris, Linda Kirchhof, Melanie

Economic influences on doctors' practice decisions.

Each year, thousands of physicians and dentists take advantage of Medical Protective's free risk management telephone consult service. Doctors call their regional consultants with a broad range of questions and concerns. It should come as no surprise that, given the current economic climate, many recent calls have had a financial component.

Physicians and dentists are worried about declining reimbursements and plummeting revenues. They're worried about increased overhead and outstanding client accounts. In response to these challenges, doctors are making changes in their practices. And, while it's a good idea to address these concerns, some of the risk management team members worry about solutions that seem focused on money without consideration of other important factors. In a kind of tunnel vision, some doctors are missing the broader picture – that healthcare requires a balance of patient safety as well as sound business practice.

Assessment of these money-focused calls indicates that the risk factors associated with them typically fit into three categories:
a) failure to take patient safety into account;
b) flawed use of human resources; and
c) operations decisions that missed the mark.

This article will use Enterprise Risk Management (ERM), (as introduced in the ERM Template on pages 8-9), to show how doctors can assess the bigger picture *and* find ways to prevent the dangerous results and legal complications that ensued in some of these cases.

1. Patient safety cannot be trumped by cost savings.

Unfortunately, there are many ways in which patient safety can be negatively affected by ill-planned business decisions. One too-common example is a disregard for the importance of infection prevention and control in any healthcare environment.

A notorious example (fortunately, not a Medical Protective case) occurred in 2002, when a Las Vegas endoscopy center triggered the nation's largest-ever infection exposure notification. At one point, health officials warned that as many as 40,000 patients might have been exposed to HIV and various strains of hepatitis.

In order to reduce costs, the clinic owners required employees to reuse syringes and single-dose vials of anesthetics. Health officials have since estimated that nearly 100 patients likely contracted hepatitis from contaminated equipment used during endoscopies and other procedures. Since these viruses often linger in the system before they are finally diagnosed, an accurate count of victims may take years.

Fix”
“Solution”

experiences and expertise of Medical Protective
Osley, and Ted Passineau.

The amount saved per patient because of this cost saving mandate is estimated to have been no more than $10 per patient.[1]

Considering the amount of publicity that this case generated, it might be assumed that, regardless of their type of practice, healthcare professionals everywhere would tighten up their own infection and prevention control activities. Countless resources are available from government and state websites and from professional associations to help providers achieve this important goal.[2] Yet, less than five years later, another Las Vegas physician lost his license under similar circumstances. While performing biopsies, this doctor reused endocavity needle guides. Authorities said that it was difficult to determine if the sole motive was savings, since the needle guides cost less than a nickel apiece.

The risk exposures are significant.

Why would an experienced doctor focus on the money without taking into consideration some of the key factors that might comprise an ERM review: a) the standard of care relative to infection prevention and control; b) the risk to patients; c) the catastrophic effects on the doctor’s practice should a patient sustain a preventable injury or health condition as a direct result of sloppy practice; d) lost potential for reimbursement/payment for injuries that may be related to healthcare-acquired injuries, regardless of their cause; and e) fines, disciplinary actions, and possible criminal charges.

Is it the hectic pace of modern healthcare that prevents some providers from focusing on the entire picture rather than just the savings potential?

Tip: *Don’t make changes without taking the time to identify the potential risks or disadvantages in addition to the anticipated benefits. Include team members in the risk analysis and, when feasible, solicit expert advice from outside the practice.*

When it comes to patient safety, practice policies should be determined by the patient’s needs and not by the corporate location, the corporate structure, or the budget. The standard of care is unlikely to vary regardless of whether a specific procedure is performed in a hospital or in an ambulatory care setting.[3]

Money saving efforts should not violate accepted professional standards.

Yet another example of risk shortsightedness occurs in the dental practice – but could be extrapolated to any clinical environment where procedures might cause spattering of blood or bodily fluids. Following a dental seminar that focused on infection control guidelines, a Medical Protective risk consultant was questioned by several attendees about her recommendation that disposable personal protective equipment such as gloves, masks, and cover gowns should be replaced between procedures and that non-disposable items such as goggles, should be cleaned. The doctors couldn't see why it might be problematic to wear the same gown all day.

The consultant's reply took into account professional standards as developed by the ADA (American Dental Association), CDC (Centers for Disease Control) and APIC (the Association for Professionals in Infection Control and Epidemiology). She emphasized two primary concerns. First, the sight of a stained or bloody garment is unlikely to ease patients' anxiety about an impending procedure. So, a fresh gown is essential if the patient is to have confidence in the cleanliness of the process. Second, infection control literature provides extensive research about the transmission of infective agents in clinical environments, e.g., surgery or invasive tests. An ever-expanding body of research is also exploring how easily these same agents can spread outside of operatory sites, e.g., stethoscopes, watches, mobile phones. The administrative crackdown on "preventable" conditions increases the financial as well as the liability risks associated with poorly implemented infection control practices. The pressure for improved preventive efforts arises from a concerted effort as undertaken by organizations such as the Centers for Medicare and Medicaid (CMS), the National Quality Forum, Leapfrog, and the Agency for Healthcare Research and Quality (AHRQ).

Relative to infections occurring subsequent to dental procedures, Medical Protective closed claims data reveals some similarities to infections that occur in a medical environment. For example, a patient who sustains an infection may require aggressive medical attention, possibly even hospitalization. In addition, the patient may sustain temporary or permanent disability, including the possibility of ongoing pain. And, as with any invasive procedure, there is always the – albeit remote – risk of death.

While it is true that serious infections following dental treatment are relatively uncommon, when they do occur, they have occasionally resulted in very high loss malpractice suits.

ERM assessments might have helped identify risk management gaps – and prevented at least some of these lawsuits.

Regardless of the environment of care, factors that may complicate the defense of infection-related cases include: a) no existing formal infection control program; b) inconsistence or non-compliance with existing infection control protocols;

(Continued on page 14)

Enterprise Risk Management Review:
Exactly What Are We Trying to Accomplish?

In any healthcare practice, tunnel vision can be prevented by a team effort. For example, the clinicians may not recognize that changes in group processes or services may confuse some patients. It may be other members of the staff who recognize this confusion and who may bear the brunt of its effects when patients express misunderstanding or frustration. In any kind of change situation, team discussions can help identify the group's expectations, possible limitations and challenges, and methods for addressing them. By beginning with a broad overview and then focusing downward to the details, the healthcare team will have a much better assessment of the risks and benefits that may result from changes in their practices. The EMR template (on pages 8-9) can be used to answer the following questions:

I. High level overview: By implementing (proposed change), we hope to be able to achieve the following:

A. Improve patient safety and/or better outcomes;

B. Improve patient satisfaction, e.g., time savings, access to care, process refinement (e.g., access to consults, receipt of test results);

C. Enact risk prevention: a review and appropriate responses;

D. Clearly define expectations for savings, reduction in work processes, or other efficiencies; and

E. Benefit from improved team morale, professionalism, and effectiveness.

II. Focused review: By implementing (proposed change), we have answered the following questions:

A. Have we researched which of our competitors already provide this service? Have we assessed the market to determine if there is sufficient patient interest/need to support an additional entry?

B. Do we have the right facility, equipment, and materials? If so, do we have sufficient and adequate staff to oversee this process, including room setup, administration, cleanup, equipment checks, maintenance, and repair?

C. Can we verify the adequacy of our clinical and staff training? If not, what additional staffing and/or education will be needed? Have we verified that this new service is within the standard of care for our profession/specialty?

1. State licensing board.
2. Specialty administrative oversight.
3. Accreditation standards.
4. Credentialing bodies.
5. Professional liability underwriting review.
6. Other respected professional leadership.

D. How do we expect to pay for this – without giving the impression that, now that we have a (name the technology) in our office, every patient will suddenly "need" this test/service?

E. Can we produce consistency of results, regardless of variation in staff, location, and equipment availability?

F. Do we know which insurers do/do not reimburse for this service – and at what rate? Do we know the correct billing codes for this service? Are patients willing to pay for this service regardless of insurance coverage?

G. Will changes in our practice legitimately save us time without decreasing the quality of patient care? Have we identified potential shortcuts that could cause harm – and have we provided staff education to explain how and why shortcuts can be dangerous?

c) sketchy documentation that specific infection control procedures have been completed; and d) no record of ongoing staff education and in-service updates. Without adequate proof that an infection control plan is in place and that everyone associated with the practice adheres to it, defense of these cases has become increasingly difficult.

Tip: *Given the media outcry about drug-resistant infections, and taking into account public health policy and health insurers' warnings about preventable injuries, every practitioner, in any medical or dental practice, should have – and use – a written infection prevention program.*

2. Staffing: Trying to find balance

Because employees are often the most expensive component of the business equation, shrewd leadership tries to find effective ways to make use of talent that is already in place. However, what may seem like a good opportunity might not look so good if subjected to a comprehensive risk assessment.

The quality of the educational experience is important.

A doctor's education is his or her most valuable professional possession. And while additional education would seem like an excellent way to acquire additional skills and potentially attract new patients, it's important that there be no misunderstanding about the nature of the educational experience. In one instance, a Medical Protective risk management consultant recently learned about new "residency" courses that may be long on promises but a bit short on content.

There's a *déjà vu* element to this type of education. It's reminiscent of the lap choly courses of the early 1990s in which physicians were promised access to a whole new revenue stream if they learned laparoscopic techniques. Unfortunately, many of these courses failed to provide adequate training or practice time and, as a result, countless patients sustained common bile duct lacerations – and the number of gallbladder-related lawsuits soared. For doctors who hadn't mastered the new laparoscopic techniques, the new revenue stream turned into quicksand.

There are similarities between these "weekend wonder" courses of the past and various express programs, sometimes marketed today as "residencies." Many of these courses focus on elective procedures – so that the primary market is self-pay patients. This new market can seem tempting for the doctor seeking a new money-making service.

> *"What may seem like a good opportunity might not look so good if subjected to a comprehensive risk assessment."*

The concern about such courses is whether or not one- or two- day classes have sufficient rigor in their content. Does a video substitute for a clinical experience? Should a 30-minute lecture qualify as a "course?" And can it honestly be said that someone who received ten hours of "talking head" instruction is as qualified as someone who completed a semester-long class that included a series of hands-on lab cases and mentoring?

A patient who has had a bad outcome might be upset to discover that the "residency" he'd been told his surgeon had completed was not a year-long advanced study – as one most often understands the definition of the word "residency." Consequently, it might be difficult to defend such a doctor from allegations that he misled the patient about his training, if he has claimed to be a specialist in an area of practice that is not recognized by the American Board of Medical Specialties (ABMS).

Dentistry defines specialty status.

The temptation to claim specialty accreditation where none exists extends across the spectrum of healthcare services. The American Dental Association, for example, has written an advisory on its recognized areas of specialty. The advisory report reserves the category of specialist for nine areas of practice:

- Dental public health;
- Endodontics;
- Oral and maxillofacial pathology;
- Oral and maxillofacial radiology;
- Oral and maxillofacial surgery;
- Orthodontia and dentofacial orthopedics;
- Pediatric dentistry;
- Periodontics; and
- Prosthodontics.[4]

It should be noted that there is no category specifically for cosmetic dental specialists. For many dentists, the cosmetic, or aesthetic, component is part and parcel of nearly every aspect of dental treatment. Thus, there may be a philosophical rift within the profession itself and, if so, it will be resolved over time.

Malpractice insurers do not specify the standard of care for any healthcare profession. However, because of their ability to note trends in litigation, including the types of lawsuits that are difficult to defend, insurers see it as their duty to point out areas of concern. And one of these concerns is the definition of "cosmetic specialist." In the meantime, dentists should be careful not to claim to be specialists if that may give patients misimpressions about their training or experience.

Opening the door to liability.

Physicians and dentists should avoid the appearance of claiming to have credentials that they don't have, e.g., calling a class or a workshop a "residency." Transparency in one's educational achievements should reflect the hard work and dedication of a respected healthcare professional. It's a bad idea to suggest, even by innuendo, a skill set that, upon closer inspection, might seem inflated.

To have claimed the same educational standing as doctors who have completed comprehensive programs may automatically hold the doctor to a higher standard of care. He or she could indeed be expected to produce the same results as those who really are specialists. And, if a patient has a bad outcome and files a claim, it is possible that the expert witness in such a case will be a fully accredited specialist. Having set himself up as a specialist, the defendant may be held to that higher standard.

Are employees working within their own scope of practice?

While the idea of additional training may be a sound investment in practice growth for any healthcare practitioner, it's generally not a good idea, as one ophthalmology group planned, to train medical assistants to conduct hearing tests. Their intent was to offer hearing tests to the practice's patients and then refer them to a local audiologist, thereby earning a commission for these referrals. An ERM review of this proposal would suggest that the doctors and staff may be practicing outside their specialty. Aside from possible Stark violations, it would be difficult to claim that this is a "service" for patients since, in many instances, they would have to be tested again, this time by a qualified professional, thus wasting patients' time and money.

Tip: *Far better to generate additional income within the practice's area of expertise, this consultant suggested. "If you're an ophthalmologist, hire an optometrist and generate revenue in an area that really does provide a service to your patients and that won't stir up a potential turf battle with the qualified ENTs in town." Another ERM insight might suggest consulting with one's malpractice carrier to determine whether or not a potential new service qualifies under an existing policy.*

Surveying all the opportunities.

Nearly every medical specialty in the U.S. is experiencing doctor shortages. For specialists, there seem to be no shortage of opportunities. For primary care doctors, holistic and preventative care are among the fastest growing types of medical practice in the U.S. Geriatric services are in demand. It is becoming increasingly difficult in some parts of the country for people with HIV/AIDS to access primary care providers who understand the health needs of this patient population. There is an outcry for doctors who are knowledgeable about the rapidly-growing population of patients who have autism and other spectrum disorders. In fact, there's a shortage across the board of physicians and dentists who willingly accept special needs patients. It's beyond the scope of this article to suggest ways to increase revenue. The point is that any avenue pursued will have a learning curve – and associated expenses – before the revenue stream begins to flow.

"A professional and supportive staff can smooth the way for patients to express their complaints and can expedite prompt and appropriate responses."

Savvy hiring decisions.

In order to address additional administrative burdens, many medical and dental practices must consider whether to hire additional non-clinical employees, such as compliance specialists, billing managers, coders, HIPAA officers, or IT staff. Risk management experts suggest that doctors consider whether some duties can be accomplished by individuals or companies outside the practice. Responsibilities like HIPAA oversight and corporate compliance can be competently managed by qualified third parties. Independent companies can also manage much of a larger practice's human resources function, especially staff education, which is frequently overlooked.

For a growing practice, there are several potential benefits in outsourcing the billing process, while retaining existing staff for other duties. First, coding has become increasingly complex – and it is a critically-important function since the practice takes a direct financial hit with every flawed submission. Second, costs

expand when a practice must hire additional coders or purchase expensive training programs so that current staff can master new coding requirements. Third, this may be the point where an ERM assessment would identify the benefits of risk transfer – letting an experienced third party assume legal accountability for the accuracy and timeliness of filed claims.

Regardless of the services that may be outsourced, it is still important that the practice's senior leadership understand these processes and take responsibility for their proper functioning. Without sufficient oversight, the potential for process breakdown increases.

Tip: *Consider outsourcing functions rather than eliminating jobs. Some administrative duties can be done by qualified vendors and existing employees can be assigned to new duties.*

Deploying or downsizing the troops.
Like new fashions, business schemes and management styles come in waves. Every year, new books about corporate leadership and management styles hit the bookstores. Many of these books use euphemisms like "reorganizing" and "reengineering" and "downsizing" when they really mean, "save money by eliminating jobs."

In tight economic times, small healthcare groups and practices may fall at opposite ends of the bell curve on this subject. Some practice owners will flirt with bankruptcy rather than furlough loyal staff. As one dentist said, "I'll stop buying test strips before we lay off employees."

The opposite, but equally risky, approach is to cut staff to the bone. Risk managers report that, in larger practices, it is often the employees who directly interact with patients – schedulers, receptionists, medical assistants – who get pink slips. From the risk consultants' perspective, these are the very folks whose absence may erode patient safety and become apparent in patient dissatisfaction. How many times did the phone ring before someone answered? Why hasn't the prescription been called in? Why is it taking so long to get a test result?

These inefficiencies may have consequences beyond patient inconvenience. Many practices are reporting increases in the number of falls in a variety of clinical settings. Why? Because transport assistance is no longer available. It may be difficult to explain in court why no one escorted the 80-year–old patient back to the check out desk, or why the pregnant mom fell off the exam table. The jury may not be impressed by the amount of money the practice saved by eliminating services that are so clearly focused on patient safety.

Staff as sources for feedback.

Another reason that mid-level employees are so important to the balance of the practice is that many physicians and dentists don't understand how to ask for patient feedback. Patients may be loath to complain to a doctor, but they will readily open up to a staff member about their concerns. A professional and supportive staff can smooth the way for patients to express their complaints and can expedite prompt and appropriate responses.

The information about patient feedback will be increasingly important as reimbursement restrictions and tighter standards for patient safety and satisfaction are enforced. This pressure emanates from the major payers' side of the equation: health insurers and government standards. The CMS and Joint Commission have developed standards about "healthcare-acquired conditions," which pressure the entire healthcare industry to measure quality outcomes and patient satisfaction. Without this data many providers will find it difficult to participate in the new "medical home" and "dental home" arrangements that will be important components of Accountable Care Organizations (ACOs) that the feds are ramping up.

Tip: *Don't cut back on quality measurement – or on staff education to support this important influence on future practice.*

3. Operational strategies

While educational decisions or staffing decisions may be made one at a time, operational decisions are made every day, and often by different members of the staff. The urgency of some of these decisions, their variety, and the potential for inadequate communication compounds the challenges. This is the part of the business where things can fall apart quickly.

One practice, for example, decided to buy an electronic health record (EHR) system without the benefit of adequate research. They found a system they liked and discovered that they could purchase the components separately. As a cost saving strategy, they decided to delay purchase of the encryption module. Now they've been accused of a HIPAA violation due to the erroneous distribution of an electronic file.

In a similar vein, a practice outsourced its transcription service to a former employee – but neglected to formulate a new business model for this change. As a result, a flash drive containing protected health information (PHI) was lost and couldn't be retrieved, because it hadn't been mailed with any retrieval or tracing options. The group had to report the loss to CMS and provide credit monitoring for each of the individuals whose information had been lost.

Tip: *Centralize purchasing. Centralize contracts. When needed, bring in a qualified and experienced expert. Have a dollar limit beyond which some sort of due diligence process is required. Use bidding processes. Let vendors fight for your business. Get comprehensive written agreements. Beyond a certain dollar threshold, have a qualified attorney review agreements and contracts.*

He who cuts corners may wound himself on the sharp edges.

Economic forecasters claim that Americans are becoming more frugal. Not a difficult decision for tens of thousands of healthcare professionals – as long as the changes don't have negative effects on patients or staff. Here are some examples of money-saving actions that healthcare practitioners later regretted:

- An oral surgeon changed the type of gauze he'd been using. The new gauze was cheaper, so he bought a large shipment to increase the savings. Not only did it not absorb, but patients complained that it "burned." The doctor investigated and determined that there was indeed some sort of caustic irritant in the gauze. He tried to return the gauze but discovered that the purchase had been a one-time, non-refundable sale. Lesson learned.

- Many healthcare entities, large and small, are complaining about their inability to learn the point of origin for supplies they use in the course of patient care. Their concern arises out of public health warnings about contaminated toys, cooking utensils, and infant formula. However, possible damage lies closer to home, as independent testing companies in the U.S. discovered that some dental materials were contaminated with toxins like mercury or lead.[5]

Tip: *Use a risk identification strategy when shopping for bargains. Will a reduction in price significantly reduce the quality of care or make process consistency too difficult for staff to sustain?*

"The urgency of some of these decisions, their variety, and the potential for inadequate communication compounds the challenges. This is the part of the business where things can fall apart quickly."

Other examples of cost cutting initiatives include use and maintenance of the medical or dental facilities themselves. These include something as simple as the often-used strategy of shutting down the HVAC system when the office is closed. Medical Protective's risk consultants suggest that, if the unit's filters and duct system are properly cleaned and maintained, shutdown may be a sound dollar-saving option. However, in many offices those big Monday morning blasts of cold air diffuse filthy particles throughout offices, contaminating sterile materials and leaving dirty surface residue everywhere. Grimy heating and air conditioning systems have been associated with a number of fatal infectious outbreaks, such as Legionnaire's disease.

A similar consideration should be in place for those who maintain latex-free offices. It either is, or it isn't, a latex-free environment. The health of allergy-afflicted patients or staff depends on consistency.

Tip: *When implementing a cost-saving plan, implement the whole plan; otherwise, the unintended additional expenses may be overwhelming.*

Expanding service area.

Sometimes, a group will open a satellite office. Several Medical Protective risk consultants have been in those secondary offices, which often look like "wastelands." Improperly equipped and poorly-staffed, these offices may lack not just amenities but crucial equipment or supplies.

One consultant tells of an office in which the doctors were given printed lists of patients they were to see at the satellite. They did not have access to the main office's computer so they couldn't obtain background information on the patients they saw.

In another office, the nerve conduction test equipment was so unreliable that certain tests could not be performed, and sometimes patients had to be rescheduled at the main office for "additional" tests – a euphemism for "completion of the test that should have been done in the first place." Eventually, this group got into trouble for the pattern of patchwork coding they'd repeatedly used to obtain reimbursement for seemingly unrelated tests. The rule with the feds: if it happens once and you fix it, it's an accident. If it occurs repeatedly and you don't fix it, they may consider it fraud.

Tip: *Every office should be set up and maintained to meet the professional requirements of the staff and to ensure the safety of patients. If the group can't afford to do this, from the first day, then the group can't afford another office.*

Conclusion:

Sound fiscal management is critical to the survival of today's healthcare organizations. Strategies to increase revenue, ensure reimbursements, and reduce costs can be effective means of ensuring practice stability and continued profits. Risk assessment is the foundation for effective decision-making in this important task. An Enterprise Risk Management approach, like any sort of good due diligence, is worth the investment of time and effort because, like a good watchdog, it will validate the wisdom of some options and set off a warning alarm about others. ■

FOOTNOTES

1. Akre, J. Las Vegas Doctor Facing Criminal Charges As Story Unfolds. InjuryBoard. National News Desk. March 10, 2008. http://news.injuryboard.com/las-vegas-doctor-facing-criminal-charges-as-story-unfolds.aspx?googleid=29982
2. Kohn, W. G., Collins, A. S., Cleveland, J. L., et al. Guidelines for Infection Control in Dental Health-Care Settings. National Center for Chronic Disease prevention and Health Promotion. Division of Oral Health. December, 2003. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a1.htm
3. Meeting the Challenge of Patient Safety in the Ambulatory Care Setting. Patient Safety and Quality Advisory Committee White Paper. Medical Group Management Assoc. 2009. http://blog.mgma.com/free-patient-safety-in-ambulatory-care-setting-white-paper/
4. Report of the Council on Ethics, Bylaws, and Judicial Affairs. An Advisory Opinion. 5.H.2. Special Announcement of Credentials. American Dental Association. Adopted Aug. 17, 1996. Revised Dec. 10, 1999.
5. Report: Imported Dental Products Contaminated with Lead; victims Confirmed. Reuters Press Release. Feb. 27, 2008. http://www.reuters.com/article/2008/02/28/idUS10661+28-Feb-2008+BW20080228

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