Risk Management
Components of a Successful Program

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Disclosure

• Casebolt Consulting: We consult with medical groups
• Patty is a paid member of the Care Credit Ophthalmic Strategic Council

Who We Are:

• Medford, OR
• County Population: 213,000 – Jackson, 85,000 – Josephine
• Medical Eye Center: 8.5 MDs, 3 ODs, 1 PA
• Offices in two counties
• 150 Staff
• Founded 1911
• Specialties: Glaucoma, Cornea, Oculoplastics, Retina
Background-Historical Perspective

- Satellite office 1st: Lawsuit against Summit laser 1998
- Lawsuits between 2000-2014:
  - Redding laser case 2000
  - Medford laser case 2006
  - Medford laser case 2007
  - Medford laser case 2007
  - Medford CK case 2008
  - Crescent City glaucoma case 2013
- 2 Aesthetics
  - Medford laser case 2014

Resource Investment

- Numerous staff depositions
- Numerous physician depositions
  - Emotional toll
  - Schedules blocked for physicians
- 2 malpractice cases involving our doctors being deposed/trial
- Notice of first report
- PCs time

Example of a Medical Board Investigation

- Board Complaint:
  - All charts to be reviewed, copied, redacted and filed
  - Hours of conference calls and meetings in Portland with our attorney
  - 3 yrs of multi-chart review with board investigator
  - 3 yrs of monthly chart audits and filed complaint report
- OD board complaints
- OD refractions
- OD marketing/patient
- OD marketing/pro active board response yellow pages
1st Attempt-Risk Mgt. Program

- Customer Care Team- 1st attempt at risk mgt. program 2009
  - No ownership/interest/follow up
  - No comprehensive system
  - Missed entries
    - Glaucoma case- patient was not entered/staff knew patient was upset
  - No peer review system

Comprehensive Risk Mgt. Program

- Jan 2012 Hired Risk Mgt. Consultant
  - Established graded level of risk/incident reporting
  - Two databases - one locked down and protected
  - Staff training program
  - Quarterly peer review process/prompted
  - Physician behavior consumer reporting forms/process
  - Root cause analysis
  - Quality and safety committee
- Feb-Aug 2014 TDC enrollment in risk audit program

Current Risk Assessment

- Current Patient Care Coordinator Team - 3 people
  - Second level/lower complaints
  - Customer service complaint database at 1 - 2 per week (most below one per week currently)
  - Current risk program “due”
    - Latest two complaints not being followed up
    - Wait time complaints on longer external two database (will go up if apology small)
    - Root cause, action on the peer review database, will slip through the cracks
  - Thorough new staff/new provider training program
  - Thorough peer review quarterly meeting
  - Current high level "serious complaints" in database 1-201
  - Low number of open claims per TDC based on amount of subspecialists
    - Per our attorney, would expect 1-2 active suits based on our size and specialty
    - Per peer administrator, equivalent office had 1-2 providers under active board investigations at any given time
Current Challenges

- 30-50% of team's time spent on risk management
- Opportunity cost for what we could be doing
- Future debt - substantial increase even if no future suits filed
- Despite many requests, unreported cases continue
- Root cause analysis or quality safety committee not happening
- No certified risk manager
- High risks: compensation $75k to $120k
- ‘A’ acceptance from MEC providers
- Lack of ophthalmology experience
- Lack of knowledge of legal system, experience per Tom A.
- Staying current with risk management policies, laws, etc.

Opportunity

- Root cause analysis
- Administrative follow up
- Providers more involved with trends/reporting
- Targeted staff training based on trends

Components of a Successful Program:

The following slides provide suggestions for components of a successful risk management program. The presenters are not lawyers and the information is not a substitute for legal advice. You should consult with your own attorney before implementing your own program.
Establish Context/Buy-in/Ownership/Budget

- Do the owners/partners/senior management support creating a culture of risk management?
- Will you hire a risk manager/consultant to set up your program, or have an attorney sign off on your program?
- Establish accountability: Who ultimately owns the program?
- Do you have a written job description/daily duties?
- Are you using a secure database?
- What is the budget for this program?
  - ASHRM/OSHRM annual fee
  - Study guides
  - Food for peer review meetings
  - Software costs

Secure database

Separated by low and high level incidents
- Low level - not protected, available to all managers
- High level – protected, available only to peer review committee members
Official Peer Review Meeting

- Establish bylaws and keep on file
- Who runs the meeting, keeps official minutes and makes up the committee?
- How to involve non-committee members in select meetings
- Timing of meetings
- Establish protected documentation, minutes and storage
  - Peer Review - Protected as peer review data under ORS 41.675; not to be disclosed voluntarily or involuntarily.
  - Protected folder
## Identify Risks

Proactively seeking out areas of possible risk throughout the practice
- Discuss with managers
- Audit by your malpractice carrier
- See example of TDC
- Shadow each department
- Shadow tool
- Talk with the safety committee/OSHA officer
- Review patient surveys
- Patient Advisory Boards

## Areas of High Risk

- EMR carry forward from previous exam
- Lab work not followed up
- Recall system
- Staff - tech calls/medical decision making
- Staff - poor customer service “death by a thousand paper cuts”
- Poor documentation
- Marketing

## Analyze and Evaluating the Risk

Risk analysis - looking at the risk/identified by area/understanding of what the risk entails
- Prioritize each identified risk into levels of risk
- See MEC’s level of risk grid
- Consider consequence if risk is not mitigated
- Example - recall system
- Reporting - establish what criteria you will be looking at
- Complications by type by doctor
- Records returns/transfer of care
- Patient complaints by type
Manage the Risk

- Clear working procedure for when and how staff report incidents
- Paper forms available in all office areas or electronic - make sure to include peer review status
- Show MEC's grid
- Follow up on peer review action items
- Adverse event - expeditious response
- Patient and family have a personal contact i.e., patient care coordinator who shepherds client throughout
- Preliminary case review
- Notice of first report to malpractice insurer if necessary
- Post mortem/Reviewed at peer review
- Utilize malpractice insurer patient advisor, webinars, articles

Adverse Event Process
Manage the Risk- (cont.)

- Enlist help of other managers
- Development of Manager On Call group
- Risk Tests/Patient Care Coordinators (Identified ownership of program)
- Trust, Verify, Test
- Provide staff training
- Empathy
- Personal awareness - i.e., defensiveness
- Deposition, trial videos
- New doctor orientation with attorney
- New employee orientation

Incident Form
Incident Analysis Form

Staff Education-Reviews
Staff Education-News

An electromechanical patientduring surgery is supposed to have a certain 

The patient was not even identified, even in the consultation, according to the hospital. If the doctor knew that the patient had a certain condition, the procedure would have been different. The patient had a certain condition that was not even identified, even in the consultation, according to the hospital. If the doctor knew that the patient had a certain condition, the procedure would have been different.

After the medical consultation, the patient was examined by a doctor. The doctor examined the patient and identified the patient's condition. The patient's condition was not even identified, even in the consultation, according to the hospital. If the doctor knew that the patient had a certain condition, the procedure would have been different.

Staff Education-Video

https://www.youtube.com/watch?v=f16An12REeY
Other Resources

Questions?

Thanks!

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