Commentary: Exploiting the Overlap: Using Utilization Management to Reduce Medical Malpractice

Sherrie Dulworth, RN, CPHRM

This report presents a practical way in which hospitals can reduce medical malpractice exposure that is related to omissions and delays in care. We illustrate our approach using the results of a risk/medical management study performed at an acute-care hospital. Traditional risk management (RM) often focuses retrospectively on adverse events and may miss opportunities to prevent errors related to omissions and delays in care. Close-to-real-time utilization management (UM) activity offers ready potential to improve quality and reduce medical malpractice—but only if UM can work synergistically with RM. It is our conclusion that hospitals can implement systematic processes to identify and intervene in patterns of omissions and delays and improve the communication and synergy among stakeholders and thereby improve patient safety and reduce their medical malpractice risks.

Key words: Delays, hospitals, malpractice, omissions, patient safety, risk, utilization

To hospital outsiders, utilization management (UM), malpractice avoidance, and patient safety efforts deal with similar issues. Hospital managers point to the differing goals of UM, quality improvement, and risk management (RM). Curiously, few hospitals have sought to benefit from the relationship of these issues.

We present a practical way in which hospitals can reduce medical malpractice exposure by integrating their UM and RM functions. We illustrate our approach using the results of a risk/medical management study performed at an acute-care hospital.

Medical malpractice costs have become a well-publicized crisis in most states. Hospitals are experiencing the greatest medical malpractice rate increases since the mid-1980s, some as high as 400% (1). Hospitals also face increased scrutiny regarding patient safety from health care groups, consumer groups, politicians, media, and regulatory organizations. Frequent, almost-real-time UM activity offers ready potential to improve quality and reduce medical malpractice—but only if UM can work synergistically with RM.

SINS OF OMISSION?

RM often focuses on errors of commission (such as medication error) or patient accidents not directly related to clinical activity (falls or suicide). Omissions and delays in clinical care—among the leading causes of malpractice claims—have not drawn the same attention. Yet, in 1998 data from the St Paul Fire and Marine Insurance Co, the category “delayed/omitted treatment” was ranked second for frequency of claims and fourth in costliness. The average claim cost in this category was $81,500 (2). On the basis of a review of multiyear hospital loss runs and industry data, we estimate that this category represents 15–30% of a hospital’s medical malpractice costs.

Medical malpractice claims represent the tip of the iceberg in potential compensable events (PCEs) (3). (We use the term PCEs to describe sentinel events, adverse events, and close calls.) The well-known under-reporting of PCEs means that in any hospital a close examination of inpatient practices (perhaps as part of a patient safety study) will identify a larger number of critical omissions and delays than malpractice claims or reported sentinel events. We believe that reducing critical omissions and delays will, ultimately, reduce medical malpractice exposure.

DEFINING OMISSIONS AND DELAYS

For purposes of medical malpractice avoidance, we define omissions as interventions that were never or-
SILOS OR SYNERGY?

The typical hospital separates 2 important RM functions: UM and RM. UM manages risks associated with reimbursement and length of stay and operates in close to real time. The traditional RM unit focuses on patient safety and medical malpractice and reviews events retrospectively. Integrating these 2 functions can help address patient safety and medical malpractice issues more immediately.

Many hospitals already employ most of the staff needed to reduce malpractice risks created by delays within their UM and RM departments, but organizational silos prevent effective cross-use of these resources.

A typical 300-bed community hospital employs 1 or 2 people in RM. Multi-hospital systems tend to share staff across hospitals, and the staff for hospitals in such systems may be smaller. The RM personnel typically report to finance, legal affairs, or corporate compliance. This staff routinely monitors and reports sentinel events, adverse events, and close calls. In some facilities, RM is integrated with quality management.

Hospitals require larger staffs in UM than in RM because UM requires more frequent chart review for more patients and because payer contracts require closer to real-time information. The same 300-bed facility may employ 10–15 utilization/case management nurses, who typically report to the chief medical officer. The UM staff routinely reviews charts every 1–3 days to identify omissions or delays that may negatively affect commercial, Medicare, or Medicaid reimbursement. Typically, however, they do not actively intervene or flag these as RM issues.

AN URBAN HOSPITAL

Working with an acute-care hospital, we tested the practicality of UM/RM integration through a data and operations review. The purpose of the study was to identify patterns of omissions and delays in diagnosis and treatment and to determine whether routine UM operations would be able to identify and remedy those in near real time. Although the study looked at both omissions and delays, we focused primarily on delays and those omissions that a UM nurse would typically identify in a review process.

The hospital has approximately 200 beds, with about 10,000 annual acute inpatient admissions, mostly Medicare. The facility self-insures its medical malpractice claims and had had good malpractice experience—its medical malpractice claim trends have been at or slightly higher than the rate of inflation.

A 15-year medical malpractice claims loss run revealed 22 medical malpractice claims related to omissions and delays in diagnosis or treatment. This represents 14% of the total number of actual claims and 27% ($4 million) of the total medical malpractice costs paid and incurred. The average claim incurred for this category was $176,000, with a range of $1200 to $650,000.

To confirm the importance of omissions and delays, we reviewed the available charts from the past 10 years’ claims. We identified the following significant causal issues, all of which a hospital UM operation could easily identify:

- Delay in surgical consult.
- Delay in computer-aided tomography scan.
- Delay in transfer to intensive care unit (ICU).
- Omission in therapeutic anticoagulation.
- Omission in clinical follow-up of significantly abnormal laboratory tests.

We also performed a review of 50 charts selected from high-admission volume primary diagnoses of abdominal pain, pneumonia, chest pain, AMI, syncope,
cerebral vascular accident, deep vein thrombosis, pulmonary embolism, and congestive heart failure. This is a relatively small sample size of cases compared with the total number of hospital admissions; however, our experience in reviewing thousands of inpatient charts for UM purposes reveals that a review of 50–100 inpatient charts [of grouped diagnoses] can reliably identify patterns in efficiency of care.) The cases typically involved coordination among many departments. UM departments typically identify a high proportion of omissions and delays in these types of cases. Most of the cases fell within the facility's average length of stay and are, we believe, typical of the general hospital experience.

We assigned omissions and delays observed among the 50 charts into the following categories, which are applicable to both RM and UM:

- Diagnostic testing
- Cultures
- Consultations
- Treatment
- Transfer
- Operating room
- Other (such as nursing observations)

We tabulated the frequency of clinical service omissions and delays. We measured the delays by the number of hours elapsed from symptom presentation until physician ordering as well as the number of hours between ordering and clinical intervention. We further subjectively characterized those events using National Centers for Patient Safety (NCPS) (6) severity descriptors. (The NCPS Safety Assessment Code matrix uses severity rankings of "catastrophic," "major," "moderate," and "minor." Risk managers use this scoring tool and method to help rank adverse events and close calls.) In evaluating the risk of a PCE, we considered published benchmark data where available along with the individual clinical characteristics of the patient, including age, sex, mental status, clinical symptoms, and other concurrent clinical management and comorbid conditions. Particular categories of events, therefore, did not receive the same severity ranking for all cases. Some cases had multiple delays within a category, so there are more delays identified than cases reviewed.

Out of 287 inpatient days reviewed, we identified 92 omissions and delays, 51 of which we scored as potentially catastrophic. Normally, only a tiny fraction of these would become an adverse event or a malpractice case. However, within this small sample review, we identified actual adverse events that appeared attributable, at least in part, to the omissions and delays, including 5 patient deaths and 1 newly developed deep vein thrombosis. The high proportion of negative findings reflects the institution's patient mix and our case selection criteria.

We noted the following patterns of omissions and delays that, in our opinion, could have high-severity malpractice consequences. Although these findings come from a retrospective review of patient charts, our experience has led us to believe that a UM operation should be able to routinely identify these variances.

1. Delay in abdominal ultrasound for abdominal pain.
2. Delay in cardiology consultation for chest pain/AMI.
3. Omissions and delays in cardiac catheterization for AMI.
4. Omissions and delays in performing thrombolysis for AMI.
5. Delay in echocardiogram and carotid dopplers for cerebral vascular accident (CVA).
6. Delay in neurological consultation for CVA.
7. Delay in venous duplex for deep vein thrombosis (DVT).
8. Delay in lung scan for DVT.
10. Delays in transfer to ICU/coronary care unit from emergency room.

As an example, of the 10 abdominal pain cases we reviewed, we found 3 cases with delays of 20–24 hours for abdominal/pelvic ultrasound. Some delays were caused by infrastructure, whereas others reflect patterns of care. These are situations that the UM staff could readily identify.

OPPORTUNITIES AND CHALLENGES

On the basis of our medical management work in more than 100 hospitals, we believe that these findings are fairly typical, particularly in hospitals with long average lengths of stay relative to their payer mix. These results would probably surprise few medical management professionals, but raising such data internally is relatively useless (or even creates unproductive irritation) unless hospital management has an effective action plan.

The solutions we propose will establish policies and procedures to identify, log, track, and eventually mitigate the numerous causes of omissions and delays that are an important source of malpractice and quality of care issues.

We recommend that hospitals consider the following:
• Strategic risk intervention requires a commitment from executive leadership. Ideally, the chief executive officer will support an action plan to promote active risk/quality/utilization management collaboration and possible departmental restructuring. Initiatives will require more than instructions to “work more closely” or “communicate.” Specific actions include establishing new processes, benchmarks, and priorities for omissions and delay interventions. The required shift in risk/quality/utilization management closely resembles an “enterprise risk management” approach to omissions and delays. It is also important that the leadership communicate the initiative and its purpose throughout the facility.

• Begin the risk analysis process with a malpractice data analysis. Given the long tail of malpractice claims, a malpractice report must include reserve and other actuarial considerations.

• Design a retrospective chart analysis using information from malpractice claims and hospital discharge data. This review will identify, among other things, omission- and delay-related patterns and documentation issues. A way to start is by comparing length-of-stay by diagnostic groups to established benchmarks separately for commercial, Medicare, and Medicaid.

• Construct risk maps that categorize omissions and delays by diagnostic groups based on the frequency and severity of delays. Figure 1 illustrates a sample risk map for chest pain/AMI. The areas of high frequency and high severity (upper right quadrant) suggest focal points for action.

• Determine the root source of the delays, starting with the focal points identified above (infrastructure, staffing, practice patterns, or others), to help prioritize activities and use of resources.

• Staff training for both UM and RM will make a difference. Most UM nurses require training to evaluate omissions and delays from a RM perspective. Risk managers, conversely, may require training to evaluate risk prospectively or concurrently rather than retrospectively. Using actual facility-case examples for training will help establish a common platform for evaluating risks. Most facilities do not employ UM or RM staff on a “24/7” basis. Incorporating the clinical nurses and medical residents into the process works, but requires training to identify variances and accept interventions generated by the new process.

• The facility should develop a process to track omission and delay variances by department and diagnosis; however, self-reporting related to malpractice has its challenges because “fear of punishment” can result in underreporting (7).

• Inadequate clinical documentation creates malpractice, reimbursement, and length of stay risk. Ambiguous charts tend to favor the plaintiffs. The hospital should evaluate its documentation gaps as a risk issue and train clinical staff to document care so that the timing of services can be unambiguously identified. A comprehensive clinical documentation program will also support the identification of omissions and delays and justify medical necessity for stays.

CONCLUSIONS

Many hospital risk managers believe that they lack the staff resources to dedicate to malpractice or new, nonmandatory patient-safety initiatives. We believe that currently existing UM and clinical personnel can identify and fix, in close to real time, omissions and delays that reflect patient safety and medical malpractice risks. Although the unique characteristics of each facility mean that needs vary, we believe this process will work for a wide range of organizations. Although we have focused on malpractice risk, there are other reasons a facility would undertake such an initiative. They include the following:

• In today’s “hard market” of medical malpractice coverage, insurers, brokers, and reinsurers seek strong evidence from facilities that they are taking active steps to improve their risk profiles. Today, insurers routinely encourage facilities to share the actions they are taking to reduce medical malpractice risk (8).

• The Joint Commission on Accreditation of Healthcare Organizations requires hospitals to implement 2 examples of “Failure Modes Effects Analysis” as part of their overall quality measures (9). In meet-
ing this required measurement, hospitals could include examples of measurements of omissions and delays in diagnosis or treatment.

- Omissions and delays may represent poor patient quality of care, even in the absence of medical malpractice claims. Delays may also represent poor customer service, even in the absence of adverse events.

- Delays are a major cause of payer denials, especially in a per-diem environment, and a major cause of excessive lengths of stay.

By implementing a systematic process to identify patterns of omissions and delays and eliminating institutional silos, hospitals can achieve improved real-time intervention, improve their efficiency and quality, and reduce malpractice associated with omissions and delays in either diagnosis or treatment.

References


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