



**Occupational Health
+ Rehabilitation Inc**

Risk Management in Occupational Medicine

William B. Patterson, MD, MPH, FACOEM
Chief Medical Officer



Risk Management

- ◆ Definitions
- ◆ Clinical
 - Prevention
 - Management
- ◆ Business Risk Management
- ◆ Claims Management



Risk Management

Protecting the assets of an organization by undertaking activities to identify, evaluate, and reduce the likelihood of human injury and the risk of loss to the organization.



Risks

- ◆ Clinical: malpractice
- ◆ Business: reputation, fiscal
- ◆ Legal: negligence, discrimination
- ◆ Physical plant: equipment, facilities
- ◆ Environmental: air quality, violence
- ◆ Occupational safety and health: WC
- ◆ Combination of the above



Risk Control

Identifying risk prone services and situations
Analyzing those conditions
Interventions to reduce risk
Monitoring effectiveness



Loss Control

- ◆ Investigating
- ◆ Managing allegations
- ◆ Supervising disclosure
- ◆ Managing and supporting defense



Responsibilities

- ◆ Provider credentialing
- ◆ Employee health and workers' compensation
- ◆ Claims management and support
- ◆ Adherence to federal, state, and local laws and regulations
- ◆ Safety and security



Responsibilities (cont.)

- ◆ Compliance with accreditation standards
- ◆ Contract review for liability issues: e.g. service and maintenance and indemnification agreements
- ◆ Disaster management and preparedness
- ◆ Oversight of medical device event reporting, tracking, recalls



Clinical Risk Management

- ◆ Credentialing
- ◆ Mid Level Practitioners
- ◆ Preventing Errors, Interdependence
- ◆ Fitness for Duty / Return to Work
- ◆ Sexual Issues
- ◆ Experience
- ◆ Reporting, Investigation, Management



Provider Credentialing

The process by which an organization determines whether an applicant is qualified for association, membership, employment, and/or the practice of specific clinical privileges being requested.



Provider Credentialing (cont.)

- ◆ Begins with the interview process
- ◆ Ask directly about license, privileges, and credential problems
- ◆ Detailed CV review by timeline
- ◆ Reference checks
- ◆ NPDB
- ◆ State databases
- ◆ Google



Credentials Verification

- ◆ Determination that the credentials presented are authentic and valid
- ◆ Verification of training, experience and licensure
- ◆ Verification of competence
- ◆ Assessment of the data and information collected to determine if a prospective employee is qualified and competent to render acceptable quality of care to patients



Developing a Credentialing Program

- ◆ Who will be credentialed?
- ◆ Do you have job descriptions?
- ◆ What qualifications do you require?
- ◆ What credentials or documents must be submitted?
- ◆ What person, department, or committee will be responsible and accountable for this process?



Collection and Verification of Information Provided by the Applicant

- ◆ Licensure and history
- ◆ Certifications
- ◆ Educational history
- ◆ Employment history
- ◆ Medical malpractice history
- ◆ Outsourcing to a CVO



Application Requirements

- ◆ Develop formal document that allows applicant to provide information about experience and qualifications
- ◆ Consider requiring criminal background check and drug/substance screening
- ◆ Include statement that all information in application is complete and correct and incorrect or fraudulent information could result in immediate suspension or termination



Standardized Policies

- ◆ Code of Conduct
- ◆ Patient Sensitivity
- ◆ Confidentiality
- ◆ Patient Dress
- ◆ Reporting of employee incidents
- ◆ Reporting of non-employee incidents



Mid Level Practitioners

- ◆ Credentialing
- ◆ Verify clinical competence by direct observation
- ◆ Do not over delegate
- ◆ Written policies and procedures
- ◆ Comply with state requirements
- ◆ MD availability



Mid Level Practitioners

- ◆ Practice and clinical guidelines
- ◆ Monitor prescriptive practice
- ◆ Periodic chart review
- ◆ Open communication
- ◆ Review chart notes before signing
- ◆ See MD at defined intervals



Preventing Errors

- ◆ Climate of openness and reporting
- ◆ Reduced reliance on memory
 - Check lists, flow sheets, tickler systems
- ◆ Access to information
 - Hand holds, ERM, electronic connections
- ◆ Standardization
 - P & P, audits, compliance
- ◆ Training and ongoing attention to RM



Interdependence

- ◆ Staff relations
- ◆ Consultants
 - What have we done so far?
 - What are our questions?
 - What do we want them to do?
 - Written letter and reports
 - Who follows up?



Interdependence (cont.)

- ◆ When we are the consultants
 - Request information
 - Make sure you know what they want
 - Keep primary care MD in the loop
 - Do not criticize or blame another HC professional



Patient Dissatisfaction

- ◆ Waits over 30 minutes
- ◆ Rude or disinterested staff
- ◆ Inaccessibility of MD or provider
- ◆ Ineffective telephone systems that hinder communication
- ◆ Test result problems
- ◆ Poor patient education



Negligence

- ◆ Duty
- ◆ Breach
- ◆ Harm
- ◆ Causation



Duty Owed

- ◆ Physician Patient Relationship
 - Workers Compensation
 - Prevention, Preplacement, FFD
- ◆ Patients are Not the Only People to Whom a Duty is Owed
 - Drug Testing
 - IMEs
 - DOT Certification
- ◆ Captain of the Ship



Duty Owed (Cont.)

- ◆ Adhere to the Standard of Care
- ◆ Informed Consent
- ◆ Referral
- ◆ Abandonment
- ◆ Appropriate Delegation



Breach

- ◆ Standard of Care will Determine if a Breach has Occurred
 - Specialty
 - Location (less so now)
- ◆ Compliance with Policies and Procedures
- ◆ Inappropriate Delegation
- ◆ Failure to Instruct



Elements of Negligence (Cont.)

- ◆ Injury and Damages
 - No Harm – No Foul
- ◆ Causation
 - The Breach of Duty Must be the Proximate Cause of the Injury



Medical Records

- ◆ Secure them in a Locked Cabinet
- ◆ Do NOT allow the Original Records to Leave Your Possession
- ◆ Track Access to the Records
- ◆ Do NOT make any Changes to the Records
- ◆ Create a Separate File for the Claim
- ◆ Do NOT put any Information on the Claim in the Medical Record



What to Do and Not to Do (Cont.)

- ◆ Communication with the Patient
 - Do NOT Speak to the Patient About the Case after he/she has Retained Counsel
 - Ex parte Communication
 - Do NOT Communicate with the Plaintiff's Attorney
- ◆ Consider Transferring Care to Another Physician



What to Do and Not to Do

- ◆ Do NOT Talk to Other Physicians to Obtain Their Opinions
- ◆ Never Obtain Another Physician's Opinion in Writing
 - This is the function of the claims representative and the defense counsel
 - Strategic Decision
 - Discoverability



What to Do and Not to Do (Cont.)

- ◆ Never Show an Medical Expert's Opinion to the Patient or his/her Attorney



Fitness For Duty / Return to Work

- ◆ No treatment relationship
- ◆ Viewed as adversarial from the start
- ◆ Disagreements with treating MDs or patient wishes are common
- ◆ Benefits at stake
- ◆ Clear directions and questions from client
- ◆ Job description



Fitness For Duty / Return to Work

- ◆ Consent form and explanation
- ◆ Past records
- ◆ Careful exam (H&P) and an open mind
- ◆ Don't step outside your areas of expertise or the data
- ◆ Carefully written report
- ◆ PAPER TRAIL



Return to Work After Back Surgery

Mr. John M was a 58 year old truck driver referred for a FFD/RTW examination by his employer. He had been out of work for nine months with a back injury that occurred when his truck drove off the highway onto the shoulder of the road. He was wearing a seat belt and jostled around. He had been out of work for 16 of the previous 24 months on worker's compensation with back pain, and he had undergone three lumbar spinal operations and two cervical disc operations.



The Conflict

The exam was normal, and the treating orthopedist sent two clearance notes.

The physician responded with a personal, detailed letter, including literature citations and a description of heavy exertion that would be considered essential job functions and asked for the specialist's medical rationale for clearing the patient without restrictions. No response.



The Conflict

The company kept him out of work.

The patient filed a discrimination suit against the employer and a suit against the physician, arguing that the doctor was "aiding and abetting" discrimination by the employer.



The Resolution

The suit proceeded against the employer, which had filed for bankruptcy, and the physician. The state malpractice tribunal found in favor of the physician, meaning that the patient had to put up a bond of \$6,000 to proceed, which would be non-refundable if the patient lost the suit. The case went to trial, and the physician was found not liable.



Risk Management Caveat #1

Job Titles ¹ Job Description

- ◆ Employer's responsibility, although clinician may draw upon personal knowledge of workplace or similar workplaces
- ◆ Hastily drafted job description written for specific employee/candidate
- ◆ Listed essential functions that are inaccurate, unrealistic, or exaggerated



Risk Management Caveat #2

- ◆ Ensure that the employer understands the scope and limitations of examination and conclusions
 - e.g., If an employee has been on the job for even a day, it is no longer a pre-placement physical
- ◆ Clinician should consider how much information is necessary
 - Interpretation, Follow-up, Communication of results



Risk Management Caveat #3

Clinician's determination:

- ◆ Objective
- ◆ Based on job demands
- ◆ Medical, not HR, focus
 - Poor: "Not qualified for job"
 - Fair: "Not medically qualified"
 - Best: "Not medically fit to perform Essential Functions"



Lessons Learned

- ◆ Document everything. Keep a paper trail
- ◆ Be specific about job descriptions
- ◆ Read and interpret the medical literature carefully
- ◆ Reach your own independent and honest opinion
- ◆ If sued, don't panic. Prepare carefully.



Sexual Impropriety

- ◆ Patient sensitivity policy and orientation
- ◆ Dressing/undressing policy
- ◆ Provider and staff education
- ◆ Chaperones (?)
- ◆ Consider patient notification



Sexual Impropriety (cont.)

- ◆ Investigate accusations
 - provider or other senior person
 - don't jump to conclusions
 - interview claimant carefully in presence of client HR: what do they want?
 - interview your employee
 - consider interviewing others
 - reach a reasonable conclusion
 - enforce and follow up



Sexual Complaints

- ◆ Mid level practitioner:
 - credible - disciplined; recurred; fired
- ◆ MD: "nice tan"
 - poor judgment - formally counseled
- ◆ Female MD: took too long on genital exam - by the book
- ◆ MD: not credible, client agreed - no action
- ◆ X-Ray tech: probably consensual



Severity Levels

1. No injury
2. Minor injury and/or temporary impairment
3. Major injury and/or functional impairment
4. Permanent functional impairment, disability, death



Our Cases: 2001-2004

Category	Percent
1	44%
2	41%
3	14%
4	1%



Category 1

1. Child of patient stubbed toe, superficial abrasion
2. Patient hit head on doorframe
3. Patient alleges exposure to blood of employee
4. Patient alleges discrimination by discussion of PPD results in waiting room
5. Patient complained about staff interrupting examination



Category 2

1. Vasovagal reaction following injection
2. Hematoma at venipuncture site impaired work
3. Patient bruised shoulder in fall in parking lot
4. Coban wrap of finger too tight; patient alleged neuropathy
5. Alleged delay in diagnosis of ankle fracture
6. Alleged improper treatment of minor finger avulsion, complicated by osteomyelitis and partial amputation: failure to use antibiotics



Category 3

1. Possible DVT in an immobilized ankle with delayed recovery
2. Back pain, constant, treated conservatively, diagnosed with osteomyelitis
3. Abnormal hip x-ray not reviewed by provider - aseptic necrosis
4. Wrist injury, delayed recovery - provider missed abnormal x-ray and did not refer, minimized injury, possibly related to patient behavior
5. Light headed during OT - hospitalized



Category 3

1. Ankle tendon injury not promptly referred
2. Possible brachial neuritis as complication of flu shot
3. Patient required emergency surgery for cauda equina syndrome one day after exam by provider
4. Failure to diagnose shoulder dislocation



Category 4

1. Against therapist: Outside referral to PT for adhesive capsulitis
 - No X-ray
 - Turned out to have fractured humerus
2. Patient died 2 weeks post knee arthroscopy, one day post PT - possible DVT - PE (?)



Oc Docs are Real Docs

Non - work related medical conditions

- ◆ Masquerading as work related
 - back pain and prostate cancer
- ◆ Attributed to work
 - asthma and allergies
- ◆ Unrelated to work
 - hypertension
 - psychiatric disease
 - melanoma
- ◆ The more serious it might be, the better the documentation must be!!!



Reporting

1. Climate of openness, support
2. All incidents/complaints must be evaluated and investigated
3. Active medical leadership
4. Policies, communications, training
5. Complaint or a suit?



Investigation

1. Independent and open minded
2. Balance between defense and "What will the plaintiffs say?"
3. Community standard
4. Complaints
 - Interviews
 - Apology without admissions
 - Educating providers
5. Suits
 - Work with the team



Outcomes

- ◆ Most cases involve no settlement
- ◆ There is excellent potential for improved client relations
- ◆ Provider involvement makes a difference



Conclusions

1. Provider leadership and management make a difference
2. Risk Management and Quality of Care are closely related
3. Biggest clinical risks:
 - FFD/RTW
 - Sexual issues
 - Diagnosis and treatment
4. The Importance of the Team

