2024
Risk Exposure Adjustment Program

Summary

2024 Criteria	Total Maximum Credit 8%	Maximum Debit 8%
OB Department	2%	2%
Emergency Department	2%	2%
Surgery Risk and Safety	2%	2%
Improving Diagnostic Safety	1%	1%
Medication Safety – IVP	1%	1%

Prior Criteria	No Credit	Maximum Debit 2%
Apparent Agency		2%

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2024
Risk Exposure Adjustment Program

OB Criteria

Reduction of maternal and neonatal morbidity and mortality rates have become a focus of regulatory and accrediting bodies. Healthcare providers and professional organizations are expected to recognize opportunities for improvement and adopt evidence-based practices to promote safe patient care throughout the perinatal period.

IDPH's 2023 Illinois Maternal Morbidity and Mortality Report (Report), as well as reports from federal agencies and professional organizations, compel health care providers and hospitals to examine the services they provide and integrate evidence-based practices to improve the quality and safety of care provided to pregnant and postpartum individuals. Two findings in particular merit response by OB healthcare providers and hospitals to reduce the impact on maternal and newborn well-being: 1) maternal obesity, and 2) maternal behavioral health, including substance use disorder (SUD).

The 2023 IDPH report identified marked increases in chronic diseases in pregnancy, including maternal obesity which increased by 33% compared to the previous Report. Multiple sources, including ACOG's Practice Bulletin 230, Obesity in Pregnancy, link various maternal and fetal complications to significantly increased BMI. Potential maternal and newborn risks include an increased likelihood of preterm and/or cesarean birth, anesthesia/analgesia complications, positioning injuries, neonatal injury during birth, as well as other risks associated with the treatment of any patient with a significantly increased BMI. The OB team needs to anticipate those potential risks to maternal and fetal well-being, and plan to mitigate those risks.

A second concerning finding from the Report indicated SUD was the most common cause of pregnancy-related deaths during the period studied. Maternal behavioral health and SUD for all live births were above 20% in some Illinois counties. Federal and state initiatives to address SUD attempt to de-stigmatize the issue, improve accessibility to treatment and interventions, and support individuals struggling with SUD. As with any chronic condition identified during care of the pregnant individual, evidence-based, whole-person care should be provided during and following pregnancy to patients with SUD. Likewise, behavioral health conditions need to be recognized and treatment included in the maternal plan of care.

The OB Department promotes patient safety and reduces obstetrical professional liability risk by applying comprehensive risk mitigation strategies that proactively address new and evolving maternal and fetal risks, promote diagnostic safety and teamwork, improve situational awareness, are patient-centric, incorporate evidence-based processes, and encourage the use of relevant decision support tools.

I. The OB department demonstrates a commitment to improved patient safety, diagnostic safety, and risk reduction by adopting standardized clinical and operational practices through its guidelines, policies and procedures.

A. The OB department develops transfer and communication guidelines with identified birthing centers and planned home birth providers.

B. The OB department identifies other community service providers (CSP), such as doulas, and clarifies roles and limitations with the CSP, patient, nursing staff, and providers.

C. The OB department evaluates and implements processes to safely care for the pregnant/laboring/postpartum individual with a significantly increased BMI.

D. If *trial of labor after cesarean section (TOLAC)* is an option at the hospital, there is a requirement for providers to be immediately available. *Immediately available* is defined in writing as meaning under specific conditions the obstetrician and anesthesia provider are in-house, and an emergency cesarean section can be performed in less than 30 minutes.

E. The OB department utilizes pre-use and in-use oxytocin checklists for induction and augmentation.

F. The OB department utilizes an algorithm that provides guidelines for responding to Category II fetal heart tracings.

G. The OB department utilizes a neonatal hypothermia protocol that is appropriate for the level of care provided at the hospital.

H. The hospital implements safe sleep positioning and environment guidelines, including parent/caregiver education, for all infants under age one year. Although the focus is on OB patients, the expectation is that policies, procedures, practices, staff education and parent/caregiver information would apply to any department caring for this age group.

I. The OB department has a process in place to eliminate the risk of unintentional retained objects during vaginal and cesarean deliveries.

J. The OB nurses' role in managing epidural anesthesia is consistent with the AWHONN Position Statement *Role of the Registered Nurse in the Care of the Pregnant Woman Receiving Analgesia and Anesthesia by Catheter Techniques* (2020).

K. The OB department has processes in place to reduce the risk of lower extremity nerve injury (LENI) in childbirth.

L. The OB department has processes in place to assess every pregnant and postpartum patient for risk factors and symptoms of cardiovascular disease.

M. Postpartum and antepartum inpatients complete a validated depression screening tool prior to discharge, and there is a process in place to initiate referral or follow-up services when indicated by the patient's score.

N. Patients are assessed for behavioral health conditions, and appropriate treatment is continued during admission, or an appropriate referral is initiated.

O. Patients are assessed for SUD, and an appropriate plan of care, including pain control, is initiated, medication-assisted treatment is continued (if started prior to admission), and/or an appropriate referral is initiated.

P. The OB department provides postpartum patients with post-birth education specific to symptoms of complications that may occur in the postpartum period, including hemorrhage, infection, venous thromboembolism, preeclampsia, cardiovascular heart disease, depression, and SUD. Education includes instructions for seeking help in response to symptoms.

Q. The OB Department has policies and procedures regarding the performance of cord blood gases and placental pathology. The placental pathology policy/procedure or other relevant policy/procedure addresses steps to take, including completion of an appropriate waiver/release, if the mother requests to take possession of the placenta, prior to the seven-day retention period.

II. The OB department supports teamwork by providing educational opportunities that include contributing causes of diagnostic errors, case review, discussion of standardized clinical and operational practices, and training intended to standardize the response to emergency situations.

A. Education for delivering and neonatal physicians/APPs, nurses, anesthesia providers, and relevant support staff on maternal and fetal/newborn risks associated with maternal increased BMI, and processes to provide safe care is completed by November 25, 2024.

B. Education for delivering and neonatal physicians/APPs, nurses, anesthesia providers, social services/case management, and relevant support staff on maternal and fetal/newborn risks associated with maternal behavioral health and SUD, processes to provide safe care, and available resources is completed by November 25, 2024.

C. All L&D nurses, delivering physicians and APPs participate jointly in at least one quarterly educational meeting held to review cases with unexpected or adverse outcomes and "near misses." The physicians, APPs, and RNs should review fetal monitor strips and relevant maternal and fetal information as a team, and discuss best practices for responding to similar situations.

D. The OB Department conducts OB team-training simulations quarterly (at a minimum), involving all relevant L&D, postpartum and nursery nurses, delivering and neonatal physicians/APPs, anesthesia physicians/APPs, and other relevant hospital and medical staff to prepare for emergency situations that may arise during the perinatal period. At least one simulation includes ED nursing and medical staff. Community birth providers and/or EMS may also be invited to participate in the simulation. Simulations include at least any four of the following: an anesthesia/analgesia-related emergency; shoulder dystocia; maternal hemorrhage; maternal collapse; emergency cesarean section; newborn collapse outside of the delivery room.

E. 100% of L&D RNs annually complete and pass a fetal monitor interpretation competency program.

III. The OB Department, through its Quality Improvement program, demonstrates a commitment to continuously evaluate and improve patient safety, reduce risk, and improve diagnostic safety.

A. Relevant process and outcome indicators are reviewed through a diagnostic safety lens for evidence of success and/or opportunities for improvement.

B. Identification of process issues and/or the occurrence of adverse outcomes triggers a focused or intensive review, which includes evaluation of diagnostic safety related processes and implications.

C. Action plans are developed to improve the diagnostic safety process and/or mitigate the risk of recurrence of adverse outcomes.

D. Learning points are shared with staff and providers.

Up to 2 % Credit or Debit

Links to Helpful Resources:

IDPH. Illinois Maternal Morbidity and Mortality Report. October 2023. https://dph.illinois.gov/content/dam/soi/en/web/idph/publications/idph/topics-and-services/life-stages-populations/maternal-child-family-health-services/maternal-health/mmmr/maternal-morbidity-mortality-report2023.pdf

ACOG. Practice Bulletin Number 230. Obesity in Pregnancy. June 2021. https://www.acog.org/search#q=obesity%20in%20pregnancy&sort=relevancy (ACOG membership or subscription required for access)

IDPH. Illinois Infant Mortality Report December 2020 https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/illinois-infant-mortality-data-report-2020-december-0.pdf

ILPQC. ILPQC/IDPH MMRC Webinar Series: Illinois Maternal Morbidity and Mortality Report Recommendations for Clinical Practice, Part 1 Substance Use Disorders. February 02, 2024. Link to webinar recording and slide deck available at https://ilpqc.org/

SAMHSA. Evidence-Based, Whole-Person Care for Pregnant People Who Have Opioid Use Disorder. May 2023. https://store.samhsa.gov/sites/default/files/pep23-02-01-002.pdf

AAP. Safe Sleep Tools and Resources https://www.aap.org/en/patient-care/safe-sleep/

CMQCC. Toolkit to Support Vaginal Birth and Reduce Primary Cesareans. Part V. The Next Step: Integrating Midwives, Doulas, and Community-Based Care. pp. 18, 80-107. https://www.cmqcc.org/sites/default/files/Vbirth-Toolkit-with-Supplement_Final_11.30.22_2.pdf

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2024
Risk Exposure Adjustment Program

Emergency Department Criteria

Diagnostic error causes as many as one third of all malpractice claims per a 2019 study. Failure to diagnose sepsis and septic shock is a leading cause of medical negligence claims in patients of all ages. In recent claims, sepsis and septic shock from failure to diagnose necrotizing fasciitis has led to life-threatening infections, and disfigument in these patients. It is essential providers and clinical staff promptly recognize and treat infections, sepsis and septic shock.

Many children are brought to emergency departments that do not specialize in pediatrics. IPT liability claims reveal a need to improve competency and resources in order to safely treat pediatric patients and mitigate potential liability. The American Academy of Pediatrics (AAP), along with several other pediatric organizations have updated their Joint Policy Statement, "Pediatric Readiness in the Emergency Department." It is necessary for hospital emergency departments to implement the recommendations set forth in the Joint Policy Statement as well as evidence-based practices to facilitate appropriate diagnosis, care and treatment for the pediatric patient.

Identification of opportunities to improve diagnostic accuracy, timeliness and readiness for both adult and pediatric patients are crucial to enhance bedside diagnosis in the ED, and need to be implemented, evaluated for effectiveness, and monitored for compliance. The core components of the Emergency Department REAP criteria continue to be key recommendations to assist in identifying and preventing premature discharge and other potential problems that may contribute to a misdiagnosis.

I. Core Components

A. Telephone call back program

- A policy is in place regarding call backs.
- The hospital monitors compliance with the call back program on an on-going basis through data collection and analysis. Goals regarding the number of call backs attempted and the number of patients actually reached are established. If these goals are not achieved, action plans are developed to address the issues.

B. ED nurse reassesses abnormal vital signs during the patient's stay and communicates the findings to the provider.

C. The hospital is monitoring compliance with the discharge timeout, including periodic observation.

II. Improving diagnostic safety for patients in the Emergency Department

A. The ED Quality Committee or other Diagnostic Safety Improvement Team charged with efforts to improve diagnostic safety will:

- Continue to meet on a regular basis and/or have a standing agenda item to implement, review and evaluate the effectiveness of tools/processes/procedures to improve opportunities of getting it "right" and share lessons learned from peer review of diagnostic error cases.
- The ED will seek to improve the culture of safety in the ED by adopting and sustaining a multidisciplinary team training program, such as TeamSTEPPS.

B. Improve timely identification and treatment of sepsis:

- The ED participates in a multidisciplinary committee (Committee) charged with efforts to improve identification and treatment of sepsis in all patients.
- The ED and/or Committee performs a gap analysis and/or assessment of the sepsis program. This should include implementing and reviewing metrics, and evaluating if and how current tools are utilized.
- As a result of the analysis performed by the ED or Committee, relevant sepsis program tools such as guidelines, triage algorithms, order sets, clinical decision support systems, etc. are revised and updated.
- Engage patients by providing discharge education and discharge instructions specific to the individual, with a focus on sepsis. Promote education of sepsis through posters, signs, etc.
- The ED evaluates/monitors processes in place to ensure timely turnaround and notification of test results key to sepsis identification and treatment.
- The Committee/ED evaluates all missed or delayed sepsis diagnoses.
- The ED works to improve blood culture contamination rates.

III. ED Pediatric readiness

A. The ED demonstrates it has appropriate resources and competent staff to provide evidence-based emergency care within the capabilities of the hospital to pediatric patients.

B. The ED will evaluate current pediatric equipment, medication, supplies, and resources for consistency with current evidence-based recommendations.

C. The ED will identify an internal or external physician and nursing staff pediatric champion to coordinate pediatric readiness.

D. The ED will assess and develop pediatric competencies and continuing education for all ED clinical staff, including physicians, that is consistent with the services provided at the hospital.

E. The ED has a policy, procedure, guidelines and/or protocols regarding the safe administration of pediatric medications.

F. The ED will review/revise policies and procedures, guidelines, and/or protocols pertaining to pediatric sedation for diagnostics and/or treatment.

G. The ED has appropriate transfer agreements for pediatric patients who require continued care.

IV. The ED, through its Quality Improvement Program, demonstrates a commitment to continuously evaluate and improve patient safety and reduce risk, with a focus on diagnostic safety.

A. Relevant process and outcome indicators are monitored for evidence of success or opportunities to improve.

B. Serious adverse outcomes involving diagnostic error trigger the performance of an RCA.

C. Action plans are developed to improve the process and/or mitigate the risk of recurrence of adverse outcomes.

D. Learning points are transparent and shared with staff and providers.

Up to 2% Credit or Debit

References:

https://www.cdc.gov/sepsis/core-elements.html

https://www.ihainsurancesolutions.com/IHAInsuranceSolutions/media/Insurance-Solutions/HiddenLinks/2024_Sepsis-Gap-Analysis-and-Action-Plan-(002).pdf

https://publications.aap.org/pediatrics/article/142/5/e20182459/38608/Pediatric-Readiness-in-the-Emergency-Department

https://publications.aap.org/pediatrics/article/143/6/e20191000/37173/Guidelines-for-Monitoring-and-Management-of

https://publications.aap.org/pediatrics/article/150/5/e2022059673/189657/Optimizing-Pediatric-Patient-Safety-in-the?autologincheck=redirected

2024
Risk Exposure Adjustment Program

Surgery Risk and Patient Safety

Surgery related patient events are considered one of the most common causes for malpractice claims and can have a significant financial impact for IPT member hospitals. Perioperatively, surgical patients can be exposed to a multitude of preventable errors, including communication errors that can give rise to patient harm for wrong site, wrong procedure, wrong patient errors and OR fires; medication errors; and serious postoperative complications. As hospitals have increased the number of surgical cases being performed post-COVID, so has the frequency of claims related to perioperative care. In 2023 alone, IPT had 4 reported claims for wrong site procedures, and a total of 8 wrong site procedures since 2018. In the post-COVID environment there must be a renewed commitment in surgery to implement patient safety measures and reduce liability exposure.

The complex nature of surgery and surgical recovery requires seamless care coordination and communication to prevent avoidable errors. Surgical team members should be trained on handoffs to facilitate effective communication, establish clear roles, and ensure engagement of team members through implementation of best practices. Standardized tools can improve quality of information exchange and reduce failures in communication during handoffs. Handoffs of high acuity level patients transferred between the OR and ICU should be emphasized. Surgical safety checklists (SSC) should not only be performed during the time out, but during critical events and processes. Quality improvement monitoring of the SSC process can result in meaningful changes and reduction of implementation errors.

Surgical fires continue to pose a serious threat to patients and staff in the OR. Considered a preventable harm by CMS and the Joint Commission, hospitals must review organizational policies and procedures related to fire safety in the OR to align with current prevention recommendations and ensure there is a comprehensive fire safety plan in place.

The perioperative setting presents unique situations that increases the risk of a medication error – lack of physician computerized order entry, lack of pharmacy verification, multiple persons administering medications, lack of standardized labeling practices, the number of distractions, and volumes of patients. Medication safety in surgery is incumbent upon organizational oversight of medication-use processes and standardization. An interdisciplinary committee should be responsible for managing standard medication processes in surgery and be responsible for procurement and storage, retrieval and preparation, medication use/administration, and labeling of medications that are adhered to by all team members.

Enhanced recovery after surgery (ERAS) is a comprehensive program that utilizes evidence-based holistic, multidisciplinary tools/bundled interventions designed to improve outcomes after surgery and to mitigate the potential for postoperative complications. The basic principles of ERAS include attention to preoperative counseling and nutritional strategies, a focus on regional anesthesia and non-opioid analgesic approaches, fluid balance and normothermia, promotion of postop recovery strategies such as early mobilization and appropriate thromboprophylaxis, and appropriate follow-up/discharge information.

To reduce the risk of perioperative errors, improve patient safety, and decrease the potential for malpractice claims arising from surgical related events we recommend that hospitals consider the following:

I. Improve surgical team member communication

A. Perioperative Handoffs

- Review and/or revise current standardized handoff process(es) utilized for patient handoffs during the perioperative period
- Develop/adopt an OR to ICU standardized handoff process that ensures the transfer of accurate and appropriate information
- Monitor the perioperative handoff process by surgical team members for appropriate and consistent use of standardized tools
- Provide staff with education on changes to handoff policies and procedures, the implementation of new handoff tools or processes, and feedback to staff on handoff process performance

B. Surgical Safety Checklist (SSC)

- Review and update, as needed, current surgical verification processes to ensure it includes not only performance of a timeout, but also a sign-in and sign-out process
- Develop a quality process and implementation plan to evaluate the appropriate use of the SSC during the preoperative sign-in, procedure timeout, and postoperative sign-out by team members, and ensure that the implementation plan identifies critical events and processes that should result in the performance of another SSC
- Provide staff with education on use of the SSC and provide feedback on SSC performance

C. Fire Safety Plan

- Review surgical fire safety plan to ensure it is consistent with current recommendations and includes a prevention algorithm that offers interventions that can be applied to identified risks
- Annually perform a “man on fire” drill/simulation with OR staff, surgeons, and anesthesia on fire safety assessment and interventions and share lessons learned with surgery staff

- Monitor performance during the timeout to ensure a robust fire risk assessment (FRA) is performed for each surgical and endoscopic procedure and perform a quality review for all procedures with a FRA of 3

II. Improve perioperative medication safety

A. Convene a multidisciplinary team of key surgical stakeholders to identify gaps in medication safety practices as outlined in guideline statements developed by ISMP and AORN and prioritize gaps in perioperative medication systems to avoid patient harm

B. Develop and or modify policies and procedures and implement changes to align with identified gaps in safe medication practices in the perioperative area

C. Provide education to OR staff, surgeons, and anesthesia on perioperative medication safety practices

III. Maintain an ERAS program as an embedded standard model of surgical care.

A. The ERAS team/committee meets regularly to explore the components to be considered in the design and implementation of a new ERAS program, and/or reviews quality metrics collected to evaluate process compliance and patient outcomes, discuss improvements/changes to the ERAS program, and evaluate opportunities to add or update ERAS protocols. The ERAS program includes cesarean sections for those hospitals with OB services. Consideration is given to partnering with independent surgeon practices to ensure accurate communication to patients and appropriate implementation of ERAS protocols.

Up to 2% Credit or Debit

Helpful references:

AANA Enhanced Recovery after Surgery: Considerations for Pathway Development and Implementation
https://issuu.com/aanapublishing/docs/5_-_enhanced_recovery_after_surgery?fr=sY2Y2YTU2NDAxMjU

ACOG Committee Opinion
Perioperative Pathways: Enhanced Recovery after Surgery (Reaffirmed 2020)
https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/09/perioperative-pathways-enhanced-recovery-after-surgery

American Society for Enhanced Recovery
Enhance Recovery Implementation Guide
https://aserhq.org/wp/wp-content/uploads/2018/09/implemtation-guide-9-9-16.pdf

Patient Handover Real-time Assessment Guide

https://www.handoffs.org/patient-handoff-resources/

OR To ICU Handover Improvement Toolkit
https://www.handoffs.org/wp-content/uploads/2021/08/OR-to-ICU-Handover-Improvement-Toolkit.pdf

Navigating the Path to a Sustainable "PACU Pause" and Standardized Perioperative Handoff: A Quality Improvement Project

https://pubmed.ncbi.nlm.nih.gov/34802921/

ISMP Guidelines for Safe Medication Use in Perioperative and Procedural Settings
https://www.ismp.org/resources/guidelines-safe-medication-use-perioperative-and-procedural-settings

ISMP's Medication Safety Self Assessment® for Perioperative Settings
https://www.ismp.org/node/18027

Sentinel Event Alert: Updated Surgical Fire Prevention for the 21st Century
https://www.jointcommission.org/-/media/tjc/newsletters/sea-68-surgical-fire-prevention2-10-9-23-final.pdf

2024
Risk Exposure Adjustment Program

Improving Diagnostic Safety in Ambulatory Clinic Settings

Diagnostic error is a leading factor in patient safety events and a significant cause of patient harm in ambulatory care settings. The prevalence of diagnostic error has been estimated to be as high as 10 to 15% of patient visits. One study estimated approximately 12 million outpatient diagnostic errors occur annually within the US with half being potentially harmful. Diagnostic errors can result in death or significant patient morbidity, increased health care costs, and lead to medical malpractice claims. Several studies have identified diagnostic error to be the most common cause of paid claims and are generally reported as the most expensive – including those for missed/delayed diagnosis of cancer in primary care.

A comprehensive approach to improve diagnostic safety is necessary to assist the ambulatory diagnostic team in making accurate and timely diagnoses, which are communicated to patients. To accomplish this, the hospital must raise awareness among healthcare providers concerning the risk of diagnostic error and improving diagnostic safety through education/training, engaging patients and their families in the diagnostic process and developing clinical systems that assist in reducing the risk of missed/delayed diagnosis of cancer including, preventative care and screening.

To prevent diagnostic error and improve diagnostic safety in the ambulatory clinic setting the hospital should:

I. Raise awareness among ambulatory clinic setting healthcare providers concerning the risk of diagnostic error and the pathways to improve diagnostic safety

   A. Disseminate/educate/provide information to professional staff in the ambulatory clinic settings on diagnostic error, barriers to accurate and timely diagnosis, strategies for improvement, as well as information on the diagnostic team/process/responsibilities.

   B. Provide education and resources to ambulatory providers and staff regarding the current recommendations and guidelines for cancer screening. This should include but is not limited to breast, colon, lung, prostate and cervical cancer screening.

II. In the ambulatory clinic setting engage patients as members of the diagnostic team

   A. Provide patient and family education about the importance of accuracy and thoroughness when giving health history and physical information.

   B. Create environments in which patients and their families are comfortable in speaking up.

C. Provide patients with tools and information that assists them in closing the loop on laboratory and imaging test results, medication reconciliation, and participation in their diagnosis development.

D. Ensure patients and family members have access to electronic health records, including clinical notes and diagnostic testing results, to better engage patients and their families in their care and allow them to review their health records for accuracy.

- Use/add disclaimer language on preliminary test results
- Review patient/clinician patient portal communication policies and processes to ensure timely and appropriate follow-up

E. Determine patients' health care literacy level to ensure that they can effectively and meaningfully, participate in their diagnosis and care.

III. Implement tools that improve cognitive performance and communication/follow through of test results in ambulatory clinic setting

A. Adopt Closing the Loop interventions in the ambulatory clinic setting for testing and clinician referrals, such as test management, safe use of technology to communicate diagnostic results, tracking of tests, improve transition information, and communicating actions, rather than acknowledgements.

B. Utilize tools/processes/procedures to improve opportunities of getting it "right", such as: checklists, second opinions, diagnostic pauses, improved physical examinations.

C. Develop a role or job description for a patient navigator, or similar person, to assist patients in obtaining timely access to healthcare services to ensure completion of diagnosis and follow up care, including preventative care.

D. Develop and/or revise processes to prompt providers to order screening and preventative care diagnostics.

IV. Develop learning systems that support the identification of and provide feedback on diagnostic error

A. Seek to improve physician reporting through the organization's incident reporting system for potential cases of diagnostic error, and closing the loop on safety events/reports involving diagnostic error.

B. Review patient experience feedback in order to identify concerns about diagnostic performance, and develop a process to review experiences that suggest a potential for diagnostic error.

C. Adopt measurements and/or triggers that assist in the identification and evaluation of diagnostic performance/safety, such as various outcome and process measure.

1% Credit or Debit

Helpful references:
https://www.acr.org/Advocacy-and-Economics/Advocacy-News/Advocacy-News-Issues/In-the-Nov-4-2023-Issue/ACS-Releases-New-Lung-Cancer-Screening-Guidelines-to-Increase-Saved-Lives#:~:text=The%20updated%20guideline%20recommends%20yearly,or%20greater%20pack%2Dyear%20history

https://www.acponline.org/acp-newsroom/acp-issues-updated-guidance-for-colorectal-cancer-screening-of-asymptomatic-adults

https://www.cancer.org/content/dam/CRC/PDF/Public/8579.00.pdf

https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2021/04/updated-cervical-cancer-screening-guidelines

https://www.cancer.org/cancer/types/prostate-cancer/detection-diagnosis-staging/acs-recommendations.html

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4870415/

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2024
Risk Exposure Adjustment Program

Medication Safety Criteria
IVP Medications

Administration of medications via IV push (IVP) is an essential method of medication delivery to hospital outpatients and inpatients. Adverse drug events (ADEs) associated with IVP medications have resulted in IPT claims alleging significant patient injury, such as tissue injury, compartment syndrome, and adverse outcomes such as sedation, seizures, and even temporary paralysis due to over/under dosing and/or administration of the wrong drug. Studies have demonstrated IV-related ADEs are associated with over 50% of hospital ADEs.

IVP-associated ADEs may occur as a result of using unsafe work arounds during drug preparation, unnecessary dilution, breaches in aseptic technique, or incorrect rate of administration of the medication and/or flush. The Institute for Safe Medication Practices (ISMP), Infusion Nurses Society (INS), and Quality Safety Education for Nurses (QSEN) have identified that a lack of standardized education and training of student clinicians has created variation in how IVP medications are prepared, labeled, and administered. Exposure to mentors in the workplace who have developed their own processes and work arounds further contributes to the assimilation and acceptance of unsafe practices that increase the risk of patient harm during IVP drug administration.

Failure to comply with consensus and evidence-based safety practices for acquiring, preparation, dispensing and administration of IVP medications contributes to the occurrence of medication errors and increases liability exposure. IVP medication safety can be improved by standardizing education and training, acquiring ready-to-administer (RTA) injectable medications whenever possible, adoption of identified safety practices, and ongoing monitoring for deviance and adverse outcomes.

I. The organization's QAPI, P&T, or other committee (Committee) charged with oversight of medication safety practices sanctions an interdisciplinary team of clinicians with knowledge of IVP medication practices to complete a gap analysis. The gap analysis addresses:
   A. Acquisition and distribution of IVP medications
   B. Use of aseptic technique while preparing and administering IVP medications
   C. Preparation (i.e. dilution, reconstitution) and labeling by pharmacists and clinicians of non-RTA IVP medications
   D. Administration of IVP medications
   E. Availability of standardized, facility-approve IVP medication resources
   F. Skill development and competency assessment
   G. Error reporting

II. The Committee develops and implements action plans to address gaps between evidence-based safe IVP medication practices and actual performance

III. The Committee monitors the impact of the action plans by evaluating relevant metrics, adverse drug events and near misses

Up to 1% Credit or Debit

ISMP Resources: (Access is FREE, but must register and log in to view and download the documents)
Institute for Safe Medication Practices (ISMP). *ISMP Safe Practice Guidelines for Adult IVP Medications*. ISMP; 2015. https://www.ismp.org/guidelines/iv-push

ISMP. ISMP Gap Analysis Tool for Safe IVP Medication Practices. 2018. https://www.ismp.org/resources/gap-analysis-tool-safe-iv-push-medication-practices?check_logged_in=1

Other Resources:
Infusion Nurses Society. Infusion Therapy Standards of Practice. 9th edition. 2024. Journal of Infusion Nursing January/February 2024 Volume 47 – Supplement. (Available with subscription to JIN, or for purchase from INS website)

Dorn LK, Campbell E, Dion D, et al. IVP evidence-based practice checklist. Quality and Safety Education for Nurses (QSEN). January 7, 2022.

2024
Risk Exposure Adjustment Program

Apparent Agency Criteria

NOTE: This criterion is for debit only.

The hospital maintains processes to reduce the potential for allegations of apparent agency and improve defensibility of all agency-related claims. Processes include the following items:

I. The hospital clearly delineates the relationship of its physicians and advanced practice professionals (APPs) to the patient in either the general consent form or in a stand-alone form. If independent contractor language is included in the general admission/outpatient consent form, the title of this form includes the wording, "and Independent Contractor Disclosure."

The form contains language that gives clear notice to the patient about independent contractors, stating that physicians and advanced practice professionals are independent physicians/providers and not employees or agents of the hospital and that they practice their independent medical judgement in the care and treatment of their patients. If there are both employed and independent physicians, the consent form or supplemental list provided to the patient must clearly differentiate these providers. Words such as "most" or "some" are not used to describe the independent status of physicians, unless the medical staff is mixed (equivalent number of both independent and employed providers) and too large to incorporate into a list, and other methods have been explored and are not available to make the distinction.

Hospitals should list the names of individual physicians/APPs working for corporations, and not just list the corporation name, to clearly identify to a patient which physicians are part of that corporation. Should the number of physicians or APPs working for a corporation be considered too large to list, then a statement should specify that all providers working for the corporation are independent. For example, ABC Radiology Group and all radiologists are independent providers and are not employees or agents of the hospital.

If independent contractor language is on a stand-alone form, this form is signed by the patient. If contained within the general consent form, it should be in a separate paragraph within the consent form, and have a line immediately following the specific language, for the patient to sign or initial. Larger font size and/or bolding for this information is highly recommended. We recommend titling the paragraph with wording such as, "Notice of Independent Practitioners." Signature lines on general consent to treat forms must include the words "patient/legal representative".

The following statement is included in the paragraph about independent physicians: *I acknowledge that the employment or agency status of physicians and other providers who treat me is not relevant to my selection of HOSPITAL for my care*. We recommend the following attestation statement be included at the end of this paragraph: *I acknowledge that any questions about the Independent Contractor Disclosure form and the important information contained in it have been answered to my satisfaction.*

When electronic signatures are obtained, the patient is consistently provided the opportunity to review the independent contractor language, and acknowledges that any question about the form and the important information contained in it have been answered to the patient's satisfaction, prior to affixing their signature.

II. The Risk Manager performs ongoing inpatient and emergency department medical record audits to assess proper completion of consent forms, including patient initials, and develops action plans to address deficiencies.

III. Appropriate language, as above, is present in surgical, procedural, and anesthesia consent forms. If there are non-employed practitioners, such as CRNAs, or other contracted healthcare practitioners participating in patient care, their independent status must be noted on the consent form.

The risk manager reviews all consent forms generated by the hospital where patient authorization is obtained for treatment or procedures to ensure appropriate independent contractor language is included in the consent form.

IV. Advertising materials/web site have appropriate disclaimer information indicating independent status of non-employed physicians, when appropriate. Particular caution is to be exercised when physicians are employed by parent corporations, other system-owned corporations, or system-affiliated corporations, so as not to hold these physicians out as hospital employees or agents.

The risk manager establishes relationships with other departments involved in this area (marketing, IT/website, business office, etc.), so there are clear communication channels understood related to changes to be made that may affect compliance with these criteria. The risk manager periodically reviews the web site, advertising materials, etc. to ensure compliance is maintained. The risk manager works with IT or the web designer for the hospital to ensure that any changes made to the website are archived.

V. The hospital does not directly purchase or subsidize the cost of liability insurance for non-employed, independent contracting physicians or advanced practice professionals.

VI. Signs are posted in the Emergency Department, Radiology, Laboratory, Admissions Area, Outpatient/Ambulatory Surgery Department, Specialty Clinics and professional buildings

specifying that physicians/APPs who practice in the departments/areas are not employees of the hospital. Hospitals that rent space to independent practitioners in the hospital building or in a separate professional building owned by the hospital post signage in or around the rented space and the common spaces, i.e. elevators and hallways specifying that the independent physician is not an employee of the hospital. Signage on the exterior of buildings owned by the hospital where independent contractors practice does not hold out the physicians/clinics as agents/employees of the hospital. If independent or contracted services such as neuro, cardiology, etc. are listed on the exterior signage, then independent contractor language on interior signage must be prominently displayed upon entering the building. Risk managers should archive copies of all signage on an annual basis and when signage is changed or updated by taking in situ photographs of the signs.

VII. Independent physicians and contracted staff do not wear hospital ID badges, lab coats or scrubs with the hospital name on them. Independent physicians do not use letterhead with the hospital's name on it.

VIII. Contracts (including Professional Service Agreements)

A. Risk managers will perform an inventory of contracted professional services with independent physicians/APPs/groups, and review the contracts to ensure these provisions are present.

- Contain language noting the independent status of physicians/providers and that they are not employees of the hospital;
- Stipulate that it is the physician's/APP's/group's contractual obligation to purchase and maintain continuous professional liability insurance in amounts no less than those limits set forth in the bylaws for each physician/APP;
- Require separate professional liability insurance limits of no less than $1M per claim and $3M aggregate for each provider and $1M per claim and $3M aggregate for each corporation/group;
- Require that the $1M/$3M insurance coverage is in full force and effect during the term of the agreement and for an unlimited period of time after termination of the agreement;
- Do not obligate the hospital to bill for professional services of the physicians/APPs. We understand there may be arrangements where the hospital does the billing on behalf of independent physicians/APPs. If this is done, there must be a statement on the bill that is sent to the patient indicating the independent status of the physicians/APPs for whom the hospital is billing; and
- Should include mutual indemnification clauses.

B. With staffing agencies:

- Contracts with staffing agencies must contain provisions noting: the contracted agency staff is not an employee of the hospital; and professional liability insurance coverage with limits of not less than $1,000,000/$3,000,000 per occurrence will be maintained.

C. If unable to determine from the contract review that insurance coverage is adequate, the relevant Certificate(s) of Insurance is to be reviewed *(Adequate insurance coverage = minimum limits of $1/3 million for each provider; coverage is continuous; corporation has separate limits of $1/3 million; limits of coverage are not eroded by defense costs).*

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