

SPECIAL REPORT

MIEC Claims Alert

Number 40
April 2008

Why, why, why do CQI?!

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*Special Report
Claims Alert*

A publication of the Loss Prevention Department, Medical Insurance Exchange of California, 6250 Claremont Avenue, Oakland, CA 94618. Articles are not legal advice. © 2008, MIEC

Why do you have your car tuned, and check the tire pressure and oil levels in your car?

Why do you periodically check the soundness of your roof, heating system and filters, fire extinguishers, and emergency supply stash?

Why would you install a security system in your home?

Why do you recommend timely screening and baseline tests for your patients? Safety! That's why.

A solid Continuous Quality Improvement (CQI) program in an office practice increases the level of safety for patients and physicians alike. It helps physicians maintain and improve the quality of the care and treatment they provide to patients. And, it helps to ensure that physicians have the documentation that is essential to their defense in a medical malpractice lawsuit, should one be aimed in their direction.

“But I don’t have time to develop a CQI program!” Can you afford NOT to develop a CQI program? A million dollar lawsuit can really ruin your day.

Harvard’s Risk Management Foundation (RMF) has said that as many as 80% of lawsuits against surgeons stem from unfortunate problems that could have

been prevented by routinized and redundant systems in the OR. If the statistics were to be collected and quantified, the numbers would probably be similar in out-patient care. RMF goes on to say that in recent years, much attention has been paid to in-patient liability and its prevention, but not enough attention is paid to out-patient care and how to prevent losses in the medical office practice. Why wait until the studies are done to implement your own CQI program to protect **your** patients in **your** office practice?!

“CQI” is usually defined as a method of evaluating structure, processes, systems, and outcomes to identify problems and/or their causes; intervening to reduce or eliminate these problems; and continually correcting the process and improving outcomes. It is a risk management philosophy that contends that most things can be improved, and don’t have to be “broke” to be “fixed.”

CQI programs can include various components. Phasing in a CQI program in manageable increments and utilizing the talents of your well-trained staff can make implementation of a CQI program possible in even the busiest practices. This newsletter offers a few options to consider when designing a program to improve the quality of care, continuity of care, courtesy, documentation, and clinical consistency in your office practice.

Component I:

Create an office Policies and Procedures manual that doubles as an on-the-job (OJT) manual for new employees. It should include a combination of the following, according to the needs, size, and nature of the practice:

- Scheduling and triage policies;
- On-call information, and what to do when the physician is unavailable;
- Emergency procedures and responsibilities;
- Storage of supplies, drugs, crash cart, etc;
- Medication prescription and refill policies;
- Documentation requirements (staff's);
- Telephone etiquette;
- Telephone advice policies;
- How to report staff problems and complaints;
- Policy on responding to patient complaints;
- Information about your liability carrier; when and how to report claims;
- Policies on confidentiality, releasing medical records and related information;
- The importance of loss prevention activities and how to implement and maintain them;

- How to recognize and respond to the receipt of legal documents;
- Summary of state laws on informed consent and informed refusal;
- How to track lab and X-ray reports; how to report results to patients;
- Where to find, how to dispense, and how to document the dispensing of patient education materials;
- List and use of standard chart and financial forms;
- Lists of specialists (and their contact information) who send patients to the practice, or to whom the practice refers patients;
- General safety and security precautions;
- Summary of billing and collection policies;
- Lists of reportable diseases and conditions;
- Universal precautions, and how to comply with OSHA regulations;
- List of vendors for maintenance, repair, replacement of equipment;
- Grid of pre-authorization requirements for the usual 3rd party payers;
- How to withdraw from care (discharging a patient from the practice); and

- Frequency, time, and place of regular staff meetings to ensure staff-physician communication about policy changes.

A Policies and Procedures Manual not only helps in the training of new employees, but when it is current and accessible, it also ensures that staff knows where to find answers to questions about their jobs and the practice. Regular staff meetings and asking staff to sign off on new policies reinforces the sum total of staff competence.

Component II:

A staff person can assist you to manage the continuity of care and ensure consistent documentation by providing a pre- and post-exam review of patients' charts.

BEFORE a patient's appointment, the reviewer can pull the chart and review it to ensure the following:

- ◇ Allergies and medications are current (and if not, action is taken to ensure that they are updated at the visit);
- ◇ Ordered test results have been received, reviewed, initialed by a clinician as evidence of review, and appropriately filed;
- ◇ Consultants' reports have been received, reviewed, initialed by a clinician as evidence of review, and appropriately filed;
- ◇ Issues pending from the last visit are flagged to remind you to note their resolution or action to be taken, if needed.

AFTER a patient's appointment, the reviewer can retain the chart long enough to ensure the following:

- ◇ A return visit time frame (or “return as needed”) is included in the progress note;
- ◇ Tests and referrals are documented in detail;
- ◇ Subjective complaints, objective exam, physician’s assessment, and treatment plans are memorialized;
- ◇ Evidence of written and oral education is visible in the chart note;
- ◇ Detailed medication documentation (name, dose, amount, refills x n, directions) is present and legible; and
- ◇ A flag indicating the need for a next-day call back is documented, if appropriate (*see Figure 1*).

Component III:

Regular, random, or as-situations-occur chart reviews related to clinical care can increase clinical acumen and consistency among clinicians who share liability. The more closely the physicians in a group reflect the same high quality of care, the less likely it is that patients will be injured, and the less likely that differences in clinical choices will be used against one another.

Establish a list of potential adverse outcome indicators related to your specialty, such as the following:

- Adverse drug reactions;
- Extended drug (or other) therapy with no improvement;
- Injury during an office procedure;
- Missed or delayed diagnosis;
- Unexpected patient death;
- Unexpected exacerbation of patient condition;

- Emergency department visit related to why patient was treated in office;
- Overlooked abnormal pathology, laboratory, or X-ray study; or
- Other criteria chosen by physicians.

Charts can be reviewed at regular or random intervals. When a chart meets an adverse outcome criteria, it can be set aside for physician review, with a *CQI Event Tracking* form (*see Figure 2*) attached. The reviewing physician completes the form and directs the appropriate action. A designated staff member keeps a log of matched screening criteria and subsequent actions. The log is a record of adverse outcome patterns; a tool to encourage physicians’ discussions of their individual approaches to clinical problems; and an instrument to alert physicians of changes that need to be made to avoid similar future problems.

A variant clinical review is for group physicians to meet regularly to discuss an agreed-upon number of current cases. The physicians review the facts of each case, the approach to care, the patient’s response or lack thereof, and future treatment options. These meetings should be documented in a log to memorialize who attended, how many cases were discussed, and what policy decisions were made—if any—as a result.

Note: Although laws vary from state to state, generally speaking, CQI meetings and related materials in small groups are not protected from discovery by peer review laws. To protect individual physicians, neither physician nor patient names need to be used when documenting chart reviews and resultant policy changes.

Policy changes made as the result of any CQI activity **should** be documented, however.

Documentation is evidence of physicians’ efforts to continually perfect their clinical skills and nonmedical practice habits. Maintain a CQI log of actions taken, and document and date policy changes “subsequent to CQI clinical chart reviews.”

Component IV:

More medically defensible cases are settled and lost due to the poor quality of medical records than any other factor. Inadequate charting puts patients and physicians at risk. To ensure the highest standard of charting is accomplished, a documentation review mechanism can be implemented.

At chosen intervals, well-trained staff could pull random charts to review for documentation deficiencies. Using a *Documentation Review / Self-Assessment* form (*see Figure 3*), reviewers could initially screen charts using the documentation criteria on the form; then, the reviewer would set aside charts that do not meet the listed criteria so that one of the physicians can review them, and determine the necessary action to be taken, if any. The results of the periodic screenings should be tracked over time and discussed at the physicians’ and/or staff’s regular CQI meetings. Physicians or staff members who fail to meet the group’s documentation criteria should be made aware that they become the group’s weakest link, and encouraged to improve their charting to ensure patient safety and physician defensibility.

Component V:

A good CQI program also might include consideration of the doctor-staff relationship and the means to cultivate it as a practice asset. After all, your office staff is often your doctor-patient liaison, your patient relations department, the agent who

represents you on the telephone and in the office, and hopefully, your most significant office ally.

To ensure that the skilled, professional, responsible “people persons” you hire represent you well, and establish and maintain high standards for themselves in your office, consider the following:

Provide:

- adequate orientation and OJT;
- a written Policies and Procedures manual;
- in-service and external training;
- constructive feedback;
- regular staff meetings;
- an open-door policy; and
- time and/or fees for professional association memberships.

Make criticism constructive, private, respectful, specific, and timely. Document such conversations.

Keep staff informed of policy changes, and ask them to acknowledge their cooperation.

Encourage staff to ask questions, offer constructive suggestions, and participate in problem-solving and the CQI program.

Cultivate team spirit. Invite staff to tell you when there is a problem and what they have done to resolve it.

Acknowledge employees’ positive efforts.

Compliment and reward exemplary work.

Provide an occasional unexpected benefit: lunch on the office, a monthly lunch with a colleague’s comparable staff, a gift certificate, a bonus for particular accomplishment above and beyond the call of duty.

Conduct annual performance reviews that feature both positive accomplishments and room-for-improvement; archive written reviews in personnel files.

Above all, acknowledge the importance of the job that medical staff does to keep your patients satisfied and you in business.

Summary:

A meaningful CQI program benefits patients, physicians and staff. An effective CQI program establishes and maintains practice values, encourages physicians and staff to strive for constant quality development by identifying areas that need improvement, and engages all involved in a team effort.

Feel free to mix and match the components described in this newsletter, or create others, to design a CQI program that suits your office practice. To reiterate briefly:

- I. Create and maintain a current and evolving Policies and Procedures Manual;
- II. Employ a pre- and post-appointment review system to ensure that office visit efficacy is maintained;
- III. Conduct clinical reviews to maintain uniformly high standards of quality care among practice providers;

IV. Use a *Documentation Review / Self-Assessment* form to evaluate the quality of patient charts; and

V. Establish and maintain a meaningful, on-going employee training and evaluation process to ensure a skilled and cooperative staff that is attentive to CQI in your practice.

MIEC’s Loss Prevention Department staff can assist you to design, refine, and evaluate your CQI program. We have written materials on a variety of topics to educate and assist both physicians and staff. We are available to answer your questions about liability (general, not patient-specific) and office management. Please call us if we may be of assistance to you.

To Reach MIEC

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Call-back program

At the doctor's direction, selected patients—those who may be returning after a long absence; those with a new medical problem; those who are particularly anxious; or those for whom the physician has a particular concern—are called by a staff member within 48-hours of the patient's appointment. The staff person asks:

- 1) How are you doing?
- 2) Do you understand, and are you following the doctor's orders?
- 3) Have you filled your prescription (or made an appointment with the specialist; scheduled a test; or other advice follow-through)?
- 4) Is there anything you want the doctor to know about your condition?

Patients like these calls! More importantly, they provide information the doctor may need to know. Perhaps it becomes clear that the patient did not understand the physician's instructions, a question was not answered, or that a new problem has arisen. The staff member can:

- a) urge the patient to take appropriate action;
- b) calendar another appointment for the patient; and/or
- c) alert the physician of potential problems with the patient's care, among other options. Call-back programs serve everyone.

Note: Document call-back conversations, including the content of the call, as evidence of the information asked and obtained.

Figure 1

Instructions for *Figure 3*

Physicians are encouraged to periodically review a selection of their own medical records to assess and maintain the quality of their documentation. The *Documentation Review/Self-Assessment* form can be photocopied and used to document these reviews.

- Depending on the size of the practice and the quality of the documentation, it may be appropriate to use a separate form for each provider. Or, one form may be used and the reviewer may enter pertinent notes about the habits of individual providers in the "Comments" section.
- In some medical practices, an initial screening of the charts can be done by a qualified assistant using one form per chart; the assistant sets aside the charts that do not meet the listed criteria so they may be reviewed by a physician. It would also be possible to choose a specific small number of criteria to review at one time, and choose different criteria to review at each subsequent regular interval.
- The results of the periodic reviews can be tracked over time and discussed at formal or informal meetings of the practice's physicians and/or staff. The log that documents reviews may also be used to keep a record of policy changes made in response to review results.

CQI Event Tracking Form

Patient identifier: _____ Review date: _____

Screening criteria:

- Adverse drug reaction
- Extended Rx use, no improvement
- Injury during office procedure
- Missed or delayed diagnosis
- Delay in resolving medical problem
- Patient demise
- Unexpected exacerbation of condition
- Unplanned ED visit related to treatment
- Overlooked abnormal diagnostic test result
- Other _____
- Other _____

Staff reviewer: _____ Review date: _____

Physician reviewer: _____ Review date: _____

- No action required
- Continue to monitor
- Other _____

Follow-up required:

Done / date / by (initials)

Figure 2

Documentation Review Self-Assessment

Number of charts reviewed

On Date:

By:

| Criteria | + | - | N/A | <i>Comments</i> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|-----|-----------------|
| Staff | | | | |
| Charts are well-organized | | | | |
| All chart entries are dated and signed or initialed | | | | |
| All handwriting is legible | | | | |
| There are no loose slips of paper or post-it notes | | | | |
| No unexplained crossouts, writeovers, squeezed-in notes | | | | |
| There are no blank spaces on chart forms, questionnaires, consent forms | | | | |
| Reasons for visit/complaints are noted | | | | |
| Other physicians the patient sees--and why--are noted | | | | |
| Current drugs patient is taking, including prescribed, complementary and alternative, OTC and "recreational" are noted | | | | |
| Allergies or "NKDA" are noted | | | | |
| Medication orders include the indications for use, drug name, dose, amount, directions, and number of refills authorized; renewals are clearly charted | | | | |
| Medication renewals include all of the above, plus who authorized the renewal and the initials of the person who "called in" the renewal | | | | |
| Evidence of dispensed written patient education materials is charted | | | | |
| Failed, canceled, rescheduled appointments are documented in chart | | | | |
| Significant phone calls are documented (content, advice, decisions, etc.), dated, signed | | | | |
| No unsubstantiated, subjective remarks are seen | | | | |

Figure 3, Page 1

Number of charts reviewed

On Date:

By:

| Criteria | + | - | N/A | Comments |
|--------------------------------------------------------------------------------------------------------------------------------|---|---|-----|----------|
| Providers (including nonphysician clinicians) | | | | |
| Handwriting is legible throughout | | | | |
| Dictation is timely, and bears evidence of physician review and correction | | | | |
| No "Dictated but not read" stamps seen | | | | |
| Patient questionnaires are initialed by providers as evidence of review | | | | |
| Significant phone calls (including those taken while on-call) are documented (content, advice, decisions, etc.), dated, signed | | | | |
| Progress notes adequately detail scope of exam, findings, history, treatment, recommendations, and include: | | | | |
| Medical history | | | | |
| SOAP format | | | | |
| Pertinent positive and negative exam results | | | | |
| Impression or diagnosis; rule-out list | | | | |
| Treatment rendered in office and/or recommended for future visits | | | | |
| Why diagnostic tests were ordered or deferred; information reviewed by MD | | | | |
| Diagrams, when appropriate | | | | |
| Informed consent discussions | | | | |
| Informed refusal discussions | | | | |
| Documentation of noncompliance | | | | |
| Evidence of oral and written patient education dispensed | | | | |
| Unresolved medical problems are flagged, addressed and resolved | | | | |
| Follow-up advice given to patients | | | | |
| Patient-specific, unambiguous return-to-work/school orders, including limitations | | | | |
| Return visit date or timeframe for follow-up | | | | |
| Specific, unambiguous referral notes including indications, urgency, and patient understanding | | | | |

Figure 3, Page 2