MIEC

SPECIAL REPORT

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Ten Risk Reduction Resolutions for 2010

INSIDE

Special Report
Claims Alert

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Happy mid-Year to MIEC policyholders!

With a new year comes new resolutions and promises of change; why not consider some resolutions as we approach the mid-year point? In this newsletter MIEC's Loss Prevention team offers you ten risk reduction resolutions, ways for you–our insureds– to actively mitigate your liability exposure. Published studies, industry knowledge, and years of experience in claims, loss prevention and hospital risk management contribute to the contents of this newsletter. If you have already fulfilled these prudent suggestions, we commend you. If not, consider these ten resolutions for a safer 2010:

Resolution 1: I will re-evaluate primary areas of *clinical* risk in my practice and initiate change.

Every specialty carries with it clinical risks that can result in significant or severe patient injury. Identify some of those risks and develop policies and procedures to help you mitigate or eliminate the potential for patient injury and decrease your liability exposure. Resources to assist you in your efforts include your professional academies or colleges (e.g., discussions that identify areas of risk and/or changes in the standard of care), medical societies, journal articles, the Physician Insurers Association of America (PIAA) and MIEC. As your professional liability carrier, we constantly evaluate claims for frequency (how many claims) and severity (how expensive the claims are) in order to identify trends.

Realistically, it may be impossible to manage all of your risk equally; however, heightening awareness of significant clinical risks and increasing efforts to avoid them could result in fewer patient injuries and an improved claims history. The American Society of Anesthesiologists did just that in 1986 when the House of Delegates approved standards requiring qualified anesthesia personnel to be present throughout a procedure when general anesthetics, regional anesthetics and monitored anesthesia care are used, and for continuous monitoring of a patient's oxygenation (e.g., pulse oximetry), ventilation, circulation, and temperature during a procedure. Current examples of evolving standards include the use of propofol by gastroenterologists to sedate patients undergoing endoscopic procedures or variations in the use of anticoagulation therapy as determined by surgical specialists.

See **Table 1** for a list of MIEC's allegations by specialty that resulted in severe injury and high indemnity payments to patients or their families.

Resolution 2: I will develop systems to track and manage diagnostic tests, patient referrals, or failed appointments.

In October 2006, Dr. Tejal Gandhi and his colleagues published a closed claims study in the *Annals of Medicine* in which they concluded that diagnostic errors that harm patients are typically the result of multiple communication and system breakdowns. The researchers studied 307 closed malpractice claims, in which patients alleged a missed or delayed diagnosis, and found that 181 claims (59%) involved diagnostic errors that harmed patients. Some of the most common breakdowns in the diagnostic process were: failure to order an appropriate diagnostic test; failure to create a proper follow-up plan; failure to obtain an adequate history or perform an adequate physical examination; and incorrect interpretation of diagnostic tests. A more recent study, published in the November 9, 2009, edition of the *Archives of Internal Medicine,* found that 44% of diagnostic errors in medicine occurred in the testing phase–namely, failure to order, report, and follow-up on laboratory tests.

> ***"Good claims experience" dividend*** *– In 2008, in addition to the traditional dividend credits returned to policyholders, MIEC instituted the "good claims experience" dividend. Policyholders with better than average claims history may qualify for the additional credit. Call your MIEC underwriter for more information to see if you qualify.*

It is vital for you to have systems in place that will help you track and manage diagnostic test information and follow patient referrals **(see Table 2)**. This year resolve to:

A. Monitor ordered tests or consultation reports: Ask staff members to help you track ordered test and consultation reports and determine why expected reports were not received. If results are not returned, staff should call the patients to determine whether or not they completed the tests or visited the specialists as recommended. When patients confirm that they complied, the staff protects patients and you by following up with diagnostic labs and specialists to obtain results and interpretations.

B. Initial reports as evidence of review: To safeguard against overlooked diagnostic reports or consultants' letters, prohibit your staff from filing these items in patient charts until you have initialed them as evidence of your review. In electronic medical records, ensure that you "sign off" on diagnostic or consultation reports before they are scanned into the system. Reports received electronically from labs or consultants should be "tasked" to you for review and electronic signature.

C. Document patient notification in the charts: Often physicians note directly on diagnostic reports that staff should notify patients of the results or call to schedule a follow-up visit. We recommend that staff document in the charts their efforts to contact patients to report negative or normal results, plus initial and date the entries. Staff should note "per Dr. XX" when they give medical advice in addition to reporting test results. We recommend that you personally contact patients about positive test results or ask patients to return to your office in follow-up to discuss the results or the consultant's conclusions.

Resolution 3: I will develop a medication management system.

According to the PIAA, mismanagement of medications is one of the top five allegations against physicians in all specialties. Failure to properly monitor anticoagulation therapy is an area of increased risk, as is mismanagement of pain medications. MIEC's claims history certainly proves this to be true. Careless charting, illegible prescriptions, and incomplete documentation of prescription details and refills (e.g., reason for the medication, its efficacy, monitoring of therapeutic levels, and indications for changes in dosage) are among the reasons for an increase in these expensive claims.

This year consider the use of a medication control record to easily track medications and make certain that the record is kept current. In EMRs: ensure that the system enables you to e-prescribe; allows you to maintain a current list of medications and their refills, distinguishing between those you prescribe and those

prescribed by others; warns you of contraindicated medications or known drug allergies, and more.

Resolution 4: I will revisit my methods of infection control in my office.

Much attention has been brought to the fact that in recent years Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C. difficile) and Vancomycin-resistant Enterococcus infections have been identified in hospitals and other healthcare facilities at alarming rates. Community-acquired MRSA (CA-MRSA) is also increasing and is responsible for a serious type of pneumonia and skin and soft tissue infections. It is estimated that 75% of CA-MRSA cases are localized to skin and soft tissue symptoms, and are considered treatable. However, 25% of cases manifest in the medically vulnerable and its virulence increases, affecting vital organs and evolving into sepsis, toxic shock syndrome, and/or necrotizing pneumonia. CA-MRSA may be sensitive to Vancomycin, Trimethoprim-sulfa, Tetracycline and Rifampin. There is increasing resistance to Clindamycin and its utility has decreased significantly.

Infectious disease specialist and MIEC Board of Governors member Steven Una, MD, gives this advice to physicians: "Issues related to the spread of MRSA, like in the hospital, should focus primarily on hand washing or the use of alcohol-based hand cleaners. It must be noted that this simple practice is by far and away the most simple and effective way to prevent the spread of the organism. Use of barriers (e.g., gloves, etc.) is important and use of surface cleaners is helpful, but hand washing remains critical. By the way, the hand cleaners do not prevent spread of C. difficile. Most medical offices should use disposable products when possible." See **Table 3** for recommendations to prevent the spread of infections in office practices.

Resolution 5: I will educate patients consistently and document my efforts.

When patients are inadequately educated about their medical condition, treatment, medication, and/or follow-up, their lack of information may contribute to noncompliance, misunderstanding, disappointment, and/or injury resulting in an inclination to litigate. Too many physicians rely upon oral communication alone, which may easily be forgotten. Health literacy and limited English proficiency (LEP) issues also contribute to miscommunication. This year, resolve to consider *what* you communicate and *how*. Take time to ensure patient understanding. Dispense written information about diseases or conditions you treat, drugs you prescribe, and about self-care and follow-up. Use resources such as The Exchange (www.healthexchange.net) to communicate with your LEP patients and document that this information was dispensed. Effective patient education leads naturally to Resolution 6...

Resolution 6: I will obtain informed consent effectively and document the discussion.

Many surgical and medication management cases include a secondary allegation of "failure to obtain informed consent" in which a patient alleges that the risks of the procedure and other elements of the informed consent discussion were not adequately explained. You have an uphill battle to prove that you obtained informed consent if you did not document it properly. Informed consent is a *process* by which the patient gives consent to the doctor after the physician has: (1) explained the purpose of the treatment or test, its benefits and risks, alternatives and their risks, and the expected outcome; (2) answered the patient's questions (i.e., the physician, *not* a staff member); and (3) the patient gives his or her consent to proceed. Consent forms complement, but do not replace the informed consent discussion. A handwritten or dictated note about the consent discussion is more helpful in defending you than is a signed form, even in states in which a consent form is *prima fascia* evidence of consent given.

Informed consent discussions documented in preoperative consultation reports or progress notes or in H&Ps are more effective than those documented in operative reports or procedure notes, which are usually created after the procedure and inevitably appear to be self-serving if a surgical complication occurs.

Conversely, patients have the right to decline hospitalization, referral to specialists, or other recommended treatment. In California, a Supreme Court decision obliges physicians to explain the possible risks or consequences of the patient's choice to decline or

refuse a physician's recommendation. Only after the patient has been given this information can it be said the patient has given an "informed refusal." The discussion and refusal should be documented. Although physicians in other states are not obligated by the California decision, we recommend that you document those discussions as evidence that the patient was given adequate information with which to make an informed refusal decision.

Resolution 7: I will consider purchasing an electronic health record.

Now is the time to consider an investment in an electronic health record (EHR). Incentives, such as President Obama's stimulus package for Medicare/Medicaid providers who incorporate "meaningful use" standards when documenting electronically, might encourage you to contemplate the purchase of an accredited electronic health record. There are numerous advantages to documenting electronically versus the traditional paper chart. Many current systems allow you to: e-Prescribe; manage medications; alert you to known allergies or contraindicated medications; simplify follow-up on ordered labs or referrals; develop documentation tools to increase easy record-keeping; and increase access to co-treaters' records.

To date, liability risks associated with EHRs focus primarily on the misuse of the systems. For example, failure to document completely or accurately because the physician was not familiar with all the EHR's record-keeping features is one form of misuse. Overstating what occurred during an office visit (e.g., documenting "normal exams" with details that far exceed the actual visit for the purpose of billing at a higher level) and documenting by exclusion are other identified misuses of an EHR.

The advantages of EHRs far outweigh their disadvantages. When used effectively an EHR will assist you in your efforts to document your decision-making, judgment, and management of patients' care, ultimately providing evidence that you practice quality medical care and comply with the standard of care.

Resolution 8: *For surgeons* – I will ensure there is adequate surgical clearance before taking my patients to surgery and ensure the effective reinstitution of medications post-operatively.

Both patient and physician are likely to suffer when important medical information is not elicited, identified or documented prior to surgery. Missing data may include: allergies, drug use, cardiac conditions, and other issues that could impact surgical intervention. Many surgeons with whom Loss Prevention has met indicate that they rely upon anesthesiology services in hospitals or a patient's primary care physician to ensure that the patient is an appropriate surgical candidate. MIEC's claims experience has proven this position to be dangerous, ultimately increasing the surgeon's liability by improperly operating on a patient whose medical history contraindicates the decision. This year, implement a system to ensure that you are personally reassured that your patients are appropriate surgical candidates and document your understanding. Review and initial pre-operatively ordered tests (e.g., chest X-rays, labs, EKGs) or indicate your review in the History and Physical (H&P) reports.

Likewise, MIEC's claims history reveals cases in which the surgeon's post-operative orders or discharge instructions failed to advise patients when to restart their Coumadin or their insulin, etc., resulting in pulmonary embolism, deep vein thrombosis, and other injuries. This year, consider using the Medication Reconciliation form or your H&P to assist you when writing post-op orders and discharge instructions. An EHR that allows you access to your patients' charts is also an excellent resource to remind you of pre-operative medication. Work with your midlevels and nursing staff to ensure critical medications are re-started post-operatively.

Resolution 9: I will document significant telephone communication with my patients and my colleagues' patients when I am on-call.

Some of MIEC's most costly paid claims involve physicians' failure to document conversations with patients while on-call. Huge losses have resulted when patients suffered catastrophic injury deemed to be the result of a telephone communication in which an on-call physician allegedly failed to advise the patient to

go to the ED or to take definitive steps to avoid injury. In these cases, MIEC's claims representatives and defense attorneys *were confident* that the on-call physicians gave appropriate advice to the patients. However, the lack of documentation memorializing the conversations made it impossible to prove.

This year, develop a method for documenting these vital conversations. Dictate a note immediately after the telephone call (date and time the call). Call your office voicemail or call services with a reminder to document the call. Use your cellphone memo function. If you have an EMR, create a contemporaneous note that includes what a patient communicated to you, advice you gave, evidence of patient understanding and any indications whether or not the patient intends to comply or refuse your advice. If covering for a colleague, ensure that the documentation is promptly forwarded to the patient's treating physician.

Resolution 10: I will invest in staff members who will increase patient satisfaction and enhance the physician-patient relationship.

Perhaps one of the most valuable resolutions you can make in 2010 is to surround yourself with staff members who will promote a healthy physician-patient relationship and contribute to increased patient satisfaction, the number one deterrent to litigation. Work with a team: who will "have your back;" who will serve as your public relations ambassadors by communicating effectively with your patients; who will not expose you to liability by giving medical advice or refilling medications without your authorization; and who will extend to patients the care and concern you have for them.

If any one of us at MIEC can be of service, please do not hesitate to call. Historically, we've partnered with policyholders to keep your premiums low and this year, as we enter a new decade, we will continue to assist you in your efforts to promote patient safety while you increase patient satisfaction and decrease your liability.

Our thanks to former Loss Prevention Managers David Karp and Judy Huerta for their contributions to this newsletter.

TO REACH MIEC

Phone:
Oakland Office: 510/428-9411
Honolulu Office: 808/545-7231
Boise Office: 208/344-6378

Fax:
Loss Prevention: 510/420-7066
Oakland: 510/654-4634
Honolulu: 808/531-5224
Boise: 208/344-7903

Email:
Lossprevention@miec.com
Underwriting@miec.com
Claims@miec.com

MIEC on the Internet:
www.miec.com
Outside: 800/227-4527

Allegations, by specialty and the precipitating injuries

Cardiovascular surgery: Most of MIEC's high indemnity cardiovascular surgery claims have dealt with negligent performance of a CABG; aortic root replacement; wrong site surgery; and negligent treatment of saddle embolus resulting in death.

Emergency medicine: Failure to diagnose dissected aortic aneurysm resulting in death; failure to diagnose meningitis, infection or subdural hematoma.

Gastroenterology: Negligent performance of colonoscopy resulting in perforation; negligent ERCP; failure to diagnose colon cancer.

General surgery: Aside from procedures found to be improperly performed, we've handled numerous claims involving miscommunication between members of the treating medical team that resulted in mismanagement of patient care and severe injury.

Neonatology: Failure to diagnose and treat hyperbilirubinemia resulting in severe injury or death.

Neurosurgery: Negligent laminectomy/discectomy resulting in paraplegia, nerve root injury, leg weakness; in at least three high indemnity cases, experts questioned the approach chosen (posterior vs. anterior).

Pain management: Improper performance of interventional procedures (e.g., overly aggressive management — multiple levels) resulting in long term injury; mismanagement of narcotics, specifically, overdose via Fentanyl patches.

Pediatrics: Negligent treatment of encephalitis resulting in death.

Plastic surgery: Aside from procedures found to be improperly performed, we've handled numerous claims in which poor post-operative management resulting in injury was alleged.

Primary care: Mismanagement of chronic conditions, such as diabetes and hypertension, resulting in permanent injury; failure to diagnose and treat cancer or impending stroke.

Radiology: Failure to diagnose cancer (breast, lung, colon).

Table 1

MIEC Offers Free On-line CME to Policyholders

Medical Insurance Exchange of California (MIEC) is pleased to announce on-line CME free to all policyholders. MIEC has partnered with Advanced Practice Strategies (APS), a CME provider that had its beginnings in Harvard's CRICO Risk Management Foundation, to provide policyholders with quality, risk reduction-oriented CME.

APS currently offers a large library covering several clinical areas. Each course was developed with nationally recognized experts from medical communities such as Harvard and Stanford. A core set of curriculum modules, applicable across all areas of practice, address general topics in risk and safety. On top of the broad core content, APS offers specialty-specific content, under constant development, that covers nearly all areas of medicine.

MIEC has purchased access to APS' courses and policyholders can now obtain AMA PRA Category I CME credits free of charge from this well respected resource.

In addition to free CME through APS, three additional affiliations currently comprise MIEC's list of "Added Benefits."

- **SecuReach**, a private voicemail system developed by a physician for physicians that is tailored exclusively for physician practices! SecuReach is a system that tracks referrals, laboratory and other tests from the time they are ordered. It automates the process of informing patients of the results—in a personalized message system that preserves the communication indefinitely. It increases office efficiency by facilitating convenient communication between physicians and their patients, thus saving time and money.

  MIEC policyholders who purchase SecuReach are eligible to receive a 10% discount off SecuReach's standard monthly fee. MIEC is "facilitating" the introduction of this service to policyholders and has no financial interests or incentives at stake.

- **The Exchange**, is a partnership of health plans, health care delivery entities, and corporate affiliates who formed to exchange information and resources about health communication and to share multilingual health materials on the internet.

  The Exchange website (www.health-exchange.net) is open to everyone, but its online library of translated health materials is available to partners or corporate affiliates only. In return for an annual membership fee paid by MIEC, our policyholders receive unlimited access to the Exchange's online PDF archive of nearly 4,000 translations of health education materials. Materials in the Exchange are free to MIEC policyholders.

- **Visible Productions**, an expansive library of anatomically structured 3D models of the human body. Visible Productions offers a library of licensable multimedia content. The library includes: complete multi-part multimedia programs, 3D medical animations, and topic segments. This media is perfect for physician-patient informed consent discussions. Visible Productions' multimedia programs include patient education programs about knee and hip replacement, lower back pain, and diabetes.

To access these resources, simply go to MIEC's website at www.miec.com. Policyholders, log in when you get to the site in order to explore and review all of the resources available to you. Learn more about the Added Benefits by clicking on the Why MIEC tab and then on Added Benefits.

Table 2

Prevent the spread of infections**

- HAND HYGIENE IS THE MOST IMPORTANT ACTIVITY THAT CAN BE PERFORMED TO PREVENT INFECTIONS! Be a role model for your practice!
- When hands are visibly soiled, before and after eating, and before and after using the restroom, hand washing with soap and water is best. Scrub for 15 seconds, or the amount of time it takes to say the alphabet. Alcohol-based hand sanitizer can be used for other contacts.
- Assure that physicians and all employees practice hand hygiene before and after touching patients or using equipment that touches patients. Hand hygiene should be regularly monitored in the office. Staff can be assigned to take turns being the "monitor" for a day to observe co-workers. Observations should be shared.
- Use gloves, gowns, goggles or protective glasses, and face shields as needed to prevent exposure to blood and bodily fluids. Hand hygiene is required after these are removed.
- Disposable patient care items should be removed from exam rooms between patients and placed in regular trash, *except*: items that are saturated with blood or bodily fluids must be placed into biohazardous waste containers.
- Medical office surfaces that are frequently touched should be cleaned regularly with germicide. Patient care items which contact skin must be cleaned with germicide after each use. Items that come into contact with open skin and mucous membranes must be sterile.
- Cover cuts and other open wounds to prevent secondary spread.
- Medications should be stored safely and temperatures must be monitored daily.
- Assure that syringes and needles are used only once per patient and disposed of properly.
- Activate safety mechanisms and dispose of sharps in the sharps container immediately after use to prevent needlestick injury.
- Provide signs promoting respiratory hygiene. Place supplies in the waiting area: tissue, masks, hand sanitizer, and trash receptacles. Patients with respiratory symptoms should be roomed as soon as possible.
- Educate your patients about the diseases and their prevention, including good hand hygiene and respiratory hygiene practices for the home.

*** Our thanks to Linda Onstad, RN, CIC, Infection Control, at Eden Medical Center in Castro Valley, California for her assistance with Table 3.*

Table 3