Who's On First, and Who's On Second?

Who is ultimately responsible for notifying the patient of important test results? If the ordering physician fails to do so, does any responsibility flow to the next provider in line, for example, the physician's nurse practitioner? Does responsibility flow outward to other providers who were not involved in ordering the test? Unfortunately, if someone drops the ball, these questions may be answered by a judge or jury in a negative way. Consider the following scenario from a case settled by SVMIC:

Eliza James* was a 70-year-old female, post-CABG (at age 67) with multiple health concerns as well as evidence of early dementia. Mrs. James was placed on low-dose aspirin, Coumadin and Plavix by her cardiologist, Dr. Aaron Smith, for atrial fibrillation. No clear-cut plan for lab work or anti-coagulation parameters were set out in her chart. Dr. Smith is a very talented, Board-certified cardiologist who employs several nurse practitioners in his busy practice, and they all saw Mrs. James.

Sporadic PT/INR levels were done for three years following Mrs. James' CABG. She ultimately required a femoral artery angiogram. Dr. Smith noted afterward that she should be on full anti-coagulation therapy. Her prior prescriptions were refilled but again, no clear orders or lab parameters were noted in her chart or in the discharge orders after the hospital procedure. (Dr. Smith later testified the discharge nurse should have included the lab orders.) Her last levels were drawn about two months prior to the procedure.

Three weeks later, Mrs. James was seen in routine follow-up by Dr. Smith's NP. Her findings included bruising—the extent and location weren't recorded—and that Mrs. James had recently restarted Coumadin *in addition to* her aspirin and Warfarin. The NP may have realized that no labs had been ordered by Dr. Smith and she apparently gave a written lab order to Mrs. James. The draw was not done for ten more days and we do not know what counseling was given to the patient about its importance.

Ironically, just five days later, Mrs. James was seen in the ED by her own PCP, Dr. Kelvin, who charted that she was on Coumadin and aspirin. She was given Keflex for an infected insect bite, which allegedly potentiated the effect of her anticoagulants.

The following day, Mrs. James was seen by Dr. Smith who charted "patient is off Coumadin but did not know why." Dr. Smith's office refilled the Coumadin on a phone request from the pharmacy. No mention was made of the pending order for PT/INR testing, nor was the patient educated about it.

Four days later, Mrs. James had her blood tested at the hospital lab per the order provided by Smith's NP (ten days earlier). The results revealed critical levels, and the hospital lab employee called Dr. Smith's office. Since it was after-hours, the answering service contacted Dr. Smith. We are uncertain about what happened at this point, but the report

was faxed to the offices of both Dr. Smith and Dr. Kelvin. It was scanned into the PCP's office notes without comment, and no action was taken.

The fax with critical values was later reviewed by a nurse at Dr. Smith's office, who wrote "handled by Dr. Smith over the weekend" and filed it in the chart. Dr. Smith testified that he called the hospital lab technician and instructed her to have Mrs. James discontinue her Coumadin. This was disputed by the technician, and there was no telephone record indicating such a call. Mrs. James' family testified that they were not notified by anyone of the result or told to discontinue the Coumadin.

Three days later, Mrs. James was seen in her PCP's office. There was no medication review and none were listed. She was given Prilosec, which allegedly potentiated the effects of anticoagulants. Though the faxed lab report was available, it was not addressed. *Keep in mind that the PCP was prescribing Aricept for diminished mental capacity/Alzheimer's type; his chart noted digitalis toxicity two years earlier and recommended that she not live alone.*

One week later, Mrs. James was seen by her PCP's nurse practitioner, who also noted bruising. Again, there was no update done of her medications and no labs were done. She was given a prescription for Omnicef, which allegedly potentiated the effect of anticoagulants.

The following day, Mrs. James was seen in Dr. Smith's office by his nurse practitioner. The chart once again documented "Off Coumadin, patient does not know why." However, the notes also indicate she was taking Coumadin along with Warfarin and aspirin daily. There was no discussion of the recent labs.

Later that same evening, Mrs. James was taken to the ED with complaints of vomiting and abdominal pain. [25-33], with elevated WBC and low RBCs. (These values were higher than upper threshold capability of hospital's equipment.) She was aggressively treated but expired two days later, allegedly from Coumadin toxicity.

What, if anything, could have been done differently that might have changed the outcome for this lady? Had Dr. Smith's office had protocols in place to address critical reports, the lab report would have been timely addressed. Some offices place medication lists and most lab reports at the chart front for each visit, requiring an active review. How does your practice handle these issues?

Should the labs have been repeated by Dr. Kelvin or his NP? He firmly believes they had no duty to monitor a medication prescribed and being monitored by a specialist. When his NP noticed bruising, she should have confirmed the INR had been done and would have seen the critical values. Also, heightened awareness of the patient's mental status warranted extra care by all parties when discussing, monitoring or changing the patient's medications.

There were talented players on the field who watched the game being lost, yet there was

no team approach, no communication, no pre-game signals worked out, that might have led to victory instead of a very sad strike-out.

*All names and locations have been changed to protect the parties' privacy.

Meeting Management

One of the unfortunate necessities of managing any organization is the need to have meetings. As medical practice consultants, we work with practices on governance and management issues. Few practices handle their meetings well. Problems range from no regular meetings to meeting too frequently, meetings without agendas, meetings that drag on forever and meetings that are totally ineffective. Below are a few tips on how to better manage meetings in your medical practice.

Agenda: Without an agenda you do not know why you are meeting. The agenda lays out the purpose of the meeting and provides a road map for the discussions.

There should be rules (policies) around how the agenda is developed – what is routinely covered, who can add items to the agenda, and who sets the agenda.

Board Materials: The Board should receive the proposed agenda at least a week before the meetings so that members are aware of the upcoming subjects. The members can add and remove items from the agenda as appropriate.

Once the agenda is finalized, a few days before the meeting, the Board should get the final agenda with an explanation of each item on the agenda. Accompanying the agenda should be the financial reports and all the background materials that will be necessary for the members to make informed decisions. With this process, the members can come to the meeting prepared to make decisions.

How Frequently to Meet? You should only meet when you can develop an agenda. If you cannot come up with an agenda, you should not meet. There should be enough time between meetings to act upon the decisions that have been made. If you meet too frequently, you will end up discussing items again before anyone has had time to react to prior decisions. If the Board is meeting too frequently, physicians will easily transition from governing to managing.

Start and Stop Times: Meetings should start on time. If you find that you are regularly waiting on Dr. Jones to start a meeting, Dr. Jones will continue to be late. People will learn to arrive on time if they realize that meetings always start at the scheduled time. An ending time is equally important. If people understand that there is a fixed amount of time to cover the agenda, everyone will work to get things done within that time frame. If there is no ending time, meetings have a tendency to run on and on without ever covering the whole agenda.

Chair vs Facilitator: Usually either the group's President or Managing Partner chair the meeting, i.e., following the agenda, leading the discussions, and calling for decisions.

It is useful to have another person, often the office administrator, to act as the facilitator. The facilitator's role is to watch the actions of those attending the meeting to ensure that no one is dominating the meeting, that everyone is contributing and providing pertinent information to the discussion.

Making Decisions: Most medical practices make decisions by reaching consensus rather than having a vote on topics. Depending on the dynamics of the group, consensus can mean different things. For some, consensus is reached after appropriate discussion and compromise—those opposing the issue agree to accept the proposed item rather than continuing to debate. For others, consensus can mean that any physician can oppose an issue and kill it. We prefer the former.

Physician boards make better decisions if they are presented with options. The operating committees and/or the manager should study the issues and bring options to the table. Just throwing out items to consider (without supplemental information) results in a lot of speculative discussion.

It is helpful to have rules around voting. It is always wise to consult the corporation's Bylaws as well as, potentially, an attorney regarding voting rules. Most items should be able to pass by simple majority or by reaching consensus. There are some issues, such as adding a new partner, that should require a super majority or even a unanimous vote. If groups have a problem with physicians bringing new items that are not on the agenda to the table during meetings, requiring those items to pass by super majority or unanimously is a good option.

Minutes: Someone (usually the manager) should be taking minutes. These can and should be very simple-just listing the item that was discussed, the vote and the action plan. There is no need to include details of the discussion. The action plan should include who is responsible for the item and when it is to be completed.

Minutes are important. In one practice we visited, the IRS requested copies of the minutes as part of their tax audit. It is very important that minutes be distributed no later than the day following the meeting. The first time the physicians see the meeting minutes should not be at the next meeting.

In conclusion, meetings are an essential part of business. Proper planning and execution can make the experience worthwhile. Short of that, they can simply be a waste of time.

Minding Your Information Through Document Retention Policies

By Justin Joy, JD, CIPP

The information contained in your practice's documents and records is one of the most valuable assets to your organization. Without this information, your practice cannot treat patients, receive compensation, or otherwise operate. With the fundamental transformation of documents from paper to digital form, storage costs and physical burdens of document management have reduced drastically. More impressive, however, has been the exponential growth in the amount of digital information that medical practices now create and maintain. Besides improving operational efficiencies through managing these tremendous volumes of information, implementing a document retention and destruction policy can also reduce risks to your practice.

As an initial matter, one person needs to be designated within your practice to be responsible for developing and maintaining the document retention policy. Of course, the designated individual can delegate tasks to others and can also bring in outside resources, such as an attorney, to assist. As with most other project-based efforts, designating a single individual responsible for developing, implementing, and administrating a document retention and destruction policy increases the chances that such an effort will actually come to fruition.

To properly manage your information, you must first know where the information is stored. Even in a smaller practice, taking inventory of your information can be a challenge. Gone are the days where a practice's documents are stored in a single records room. Today, data is stored on mobile devices, workstations, network servers, and removable media such as thumb drives and external hard drives. Information is also maintained by third parties such as cloud storage vendors and paper archiving services. While taking an inventory of your information can be complicated, it is important to know where your information is stored. Get your IT personnel involved in this process. There are tools available to help identify where data is stored. Also, reviewing vendor invoices and contracts may be helpful in determining which vendors store your information. (You will need HIPAA-compliant business associate agreements with each one of your vendors receiving and storing protected health information.)

Once you have identified where your data is stored, you must determine the different categories of information you have. This can also be a laborious process, but start simple. For instance, nearly every practice has certain categories of information such as patient data, employee and human resource information, tax information, corporate information,

and data pertaining to third-party contracts. Your practice may have additional categories. This exercise necessarily involves seeking input from different functions within your organization.

The next step is to determine how long the different types of documents you have need to be retained. Thoughtfulness—and perhaps seeking legal advice—in making retention period determinations is important. While the risk of destroying a document before it is no longer needed is obvious, what may not be as obvious is that retaining a document significantly longer than necessary may also create a risk. Data breaches are one risk of retaining stale documents. When your practice experiences a data breach, you must notify the patients affected by the breach. How would you like to notify a patient, whom your practice has not seen in 15 years and has moved to another city, about a data breach where a cybercriminal has stolen his or her Social Security number from a very old billing record?

Another risk of retaining information longer than necessary is the potential for an increased burden in employment litigation, contract disputes, and health care liability actions. While it is imperative you retain, subject to a "litigation hold," all documents pertinent to ongoing litigation or litigation that is reasonably anticipated, unnecessarily retaining unrelated documents may lead to increasing the inherently high costs and burdens associated with any legal action because of pre-trial discovery obligations.

Once a document has reached the end of its retention period, it must be properly destroyed. If a document is not properly destroyed, the benefit of an otherwise well-managed document retention policy is greatly diminished. Proper data destruction in today's digital world can be challenging. In a paper environment, once a paper document reaches the end of its retention period, it is simply shredded. Today, however, destroying, and not just deleting, all copies of an electronic document or record requires knowledge of every location where a copy is stored, which gets back to the initial step of taking a data inventory discussed above. Often, numerous copies of electronic documents are stored in multiple locations such as workstations, mobile devices, replicated servers, and cloud-based backup systems utilizing co-located data centers. IT personnel should be involved in developing a destruction plan to address these considerations.

A document retention and destruction policy requires thought and effort to put into place and administer, and once such a policy is put into place, it should be reviewed and updated periodically. The long-term benefits of the policy include increased efficiency and lowered risk, which are worth the short-term effort.

Hardship Application Open for MIPS' Advancing Care Information

By Elizabeth Woodcock, MBA, FACMPE, CPC

“Extreme and uncontrollable” circumstances provide a way out of a key component of the Merit-based Incentive Payment System (MIPS) of the Quality Payment Program (QPP). The QPP Hardship Exception Application for the MIPS program year 2017 just opened on August 2, with circumstances such as natural disasters, practice closures, and severe financial distress topping the list. Electronic health record vendor “issues” also qualify, which is consistent with the hardship applications of the recent past. According to the Centers for Medicare & Medicaid Services (CMS), which administers the program, the agency doesn’t require any documentation be submitted in conjunction with the application. CMS even purports to accept verbal applications via its customer service center. The government advises that the agency will send a confirmation email that an application was submitted – and that it is pending, approved, or dismissed. Further, CMS counsels participants: “Clinicians and groups should retain documentation of their circumstances supporting their application for their own records in the event CMS requests data validation or audit.”

In addition to “extreme and uncontrollable” circumstances, CMS is accepting applications on the basis of insufficient Internet connectivity and/or lack of control over the availability of certified electronic health record technology (CEHRT).

There may be no reason, however, to submit this application. First, the category of “advancing care information” (ACI) – the new name for meaningful use under the QPP’s MIPS – offers automatic exemptions for certain clinicians. These so-called “special status clinicians” receive automatic exemption from this category of MIPS in 2017. These include hospital-based clinicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, as well as non-patient facing and hospital-based MIPS-eligible clinicians. According to CMS, there is no need to submit an application, but you may want to double check if there are any doubts about your qualifications.

Second, this particular exemption will not relieve you from the penalties associated with program year 2017. In fact, the hardship application will simply provide a way out of the ACI *category*, not the program. The weight associated with ACI – 25% - gets transferred to the other categories. For most, that makes Quality measures worth 80% and Improvement Activities worth the remaining 20%.

Next, recognize that it's simple to comply with program year 2017. There's not even a requirement to have an EHR system to participate. Indeed, without an EHR system, you can even potentially gain a bonus by submitting quality measures via claims, and confirm your completion of improvement activities. If you want to take your foot off the brake – and just perform the absolute minimum, you can relieve yourself of any penalties by submitting confirmation that you performed one of 92 different improvement activities. Read more about the "pick your pace" optionavailable for program year 2017 only.

Finally, recognize that CMS has exempted any clinician who sees less than 100 Medicare patients a year – or receives less than $30,000 in total allowed Part B charges - from the QPP. (Confirm your exempt status at this link by keying your NPI into the "Check NPI" field.) The agency has proposed raising this minimum to 300 patients or $90,000 for program year 2018, emphasizing that this exemption would be the entire program, not just a single category. If you fit this new threshold, you may not want to invest a tremendous amount of resources into compliance with the new program. However, CMS won't announce its decision about the new exemption threshold until November.

Check out the program's website for more information.

Please see the March edition of the SVMIC Sentinel for more information on participation.

Kentucky Surgeons: July 1, 2017, Start of Government Research Study

By Elizabeth Woodcock, MBA, FACMPE, CPC

Several years ago, the Centers for Medicare & Medicaid Services (CMS) proposed a dismantling of the coding system for surgeries. Congress stepped in to block the change, but allowed CMS to study the non-surgical activity that occurs during global periods. That research study began on July 1, 2017, encompassing post-operative encounters only.

Limited to surgeons practicing in a group of 10 or more practitioners, the study was rolled out to participants in nine states.* In addition to Kentucky, Florida, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island were chosen. Only 293 codes are the target of CMS' research study. The list of codes includes surgeries that cross many specialties, such as 29876 (knee arthroscopy), 33533 (CABG) and 44205 (laparoscopic colectomy; partial with ileum).

Regardless of the place of service, patients who are seen for post-operative care should be "billed" with 99024, the designated CPT® code for these visits. The circumstance is limited to Medicare Part B patients only, but it's important to check with your clearinghouse to determine how to properly transmit the code. Most software vendors allow a $0 charge to flow through to the Medicare contractor, although some require $0.01 to be attached to the transaction. It is not necessary to connect the claim on which 99024 is reported to the claim on which the initial surgical procedure is reported.

Although there are no financial penalties for not participating, Congress granted CMS the authority to implement a 5% reimbursement withhold at its discretion. As the program just commenced, CMS has not yet acted upon the penalty, instead just requesting participation.

For more information about the government's research study, to include the list of the 293 surgeries that require post-operative coding, see this page on CMS.gov.

**CMS defines "practitioner" as physicians and non-physician practitioners who are permitted to bill Medicare under the Physician Fee Schedule (PFS) for services furnished to Medicare beneficiaries. Thus, this would include nurse practitioners, physician assistants, clinical nurse specialists and certified registered nurse anesthetists.*

Patient Portals

By Julie Loomis, RN, JD

At SVMIC, we're often asked if a practitioner can utilize the patient portal to notify patients of lab/test results that are normal and require no follow-up. The short answer is yes, you can use your patient portal to communicate lab/test results that are normal, require no immediate attention and are not of a sensitive nature provided you have the patient's consent and verification that the patient accesses the portal. *Any abnormal or unexpected result or a result requiring immediate action should not be posted to the portal until the patient is personally notified.*

The patient portal is a valuable practice management and even patient safety tool if utilized in the most appropriate and diligent way. Consider the following scenario: A patient with a remote history of breast cancer went in for her mammogram and was electronically notified of new results posted to her patient portal. Unfortunately, the mammogram identified a probable malignancy and the patient learned about the recurrence of breast cancer by checking her secure patient portal before the physician discussed the results with her. This lack of personal communication can set the stage for strained physician/patient relationships.

Use the following tips to manage results via the patient portal:

If you have confirmed that a patient has accessed the portal previously, it should be sufficient to notify patients of lab/test results via a patient portal, provided that the patient:

- has been educated on use of the portal,
- signed a written consent or electronically agreed to receive information via the portal,
- the results are normal ("normal" is a medical judgment call), and
- and the results do not contain sensitive information (e.g. STD, pregnancy, HIV, hepatitis, etc.) or require immediate action.

If you have an indication that the patient does not access results, other methods of communication will need to be utilized such as a phone call or a letter mailed First Class. The key difference between a letter being sent via First Class mail (regular "snail mail") and any form of electronic communication, including patient portal, is that there is a legal presumption the intended recipient received the letter when it is sent via First Class mail through the U. S. Postal Service. However, this presumption may not exist when the information is sent electronically. That is why we recommend that if a practice cannot speak directly with a patient after two (2) phone attempts, the information should be mailed to the patient. So long as the letter is correctly sent to the address provided by the patient, a court will presume that the patient received the letter and the practice took the necessary

steps to sufficiently notify the patient. Patient portals are useful for engaging patients when personal interaction is not a necessity, but the portal is not a substitute for in-person communication when indicated.

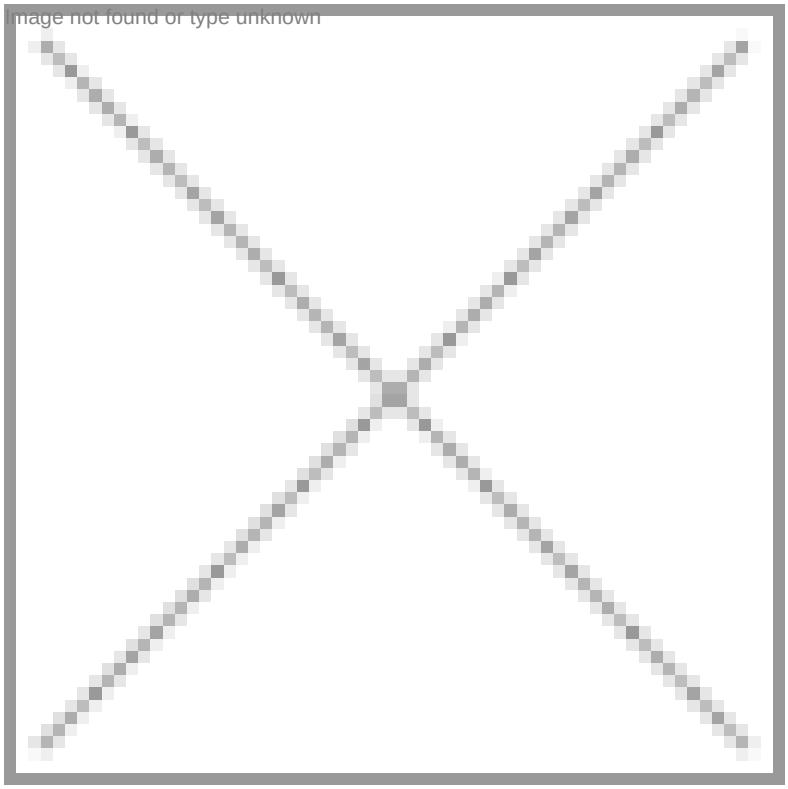
An Analysis of Interventional Pain Management Closed Claims

By Shelly Weatherly, JD

A review of SVMIC Interventional Pain Management claims with a paid loss from 2007 – 2016, reveals that medical judgment was challenged in 79% of the cases. Allegations included utilizing improper technique, failing to properly diagnose and treat a complication, failing to order proper diagnostic tests and failing to obtain a consult.

One case involved a delay in recognizing a post-procedure complication in a 52-year-old female patient who underwent a C5-6 transforaminal epidural steroid (Depo Medrol) injection under fluoroscopy. Within minutes, the patient developed a rapid onset headache, diffuse numbness, slurred speech and nausea. The anesthesiologist suspected excessive sedation as the cause of the symptoms. He evaluated the patient's neuro status by checking hand squeezes and having the patient push her foot against his hand. He determined the response was normal but failed to document this in the record. The patient was observed for 2 hours before being admitted with continued neurologic symptoms. The hospitalist who admitted the patient noted the neurologic deficits and ordered a stat CT and neurology consult. The CT showed a large right side cerebellar hematoma with cerebral edema. The patient arrested after the CT and died the next day. The autopsy revealed a pierced dura and spinal cord injury with death due to a cerebellar herniation. The subsequent lawsuit alleged inappropriate surgical technique and challenged the use of Depo Medrol as its use was under debate in the medical community. A more significant allegation was the failure of the anesthesiologist to recognize and properly treat the symptoms of stroke. Experts criticized the defendant physician for his insufficient and undocumented neurologic exam and his failure to order a neurology consult or obtain a CT.

In addition to medical judgment issues, the graph below reveals that poor documentation, medication errors and ineffective communication were significant issues.



DOCUMENTATION ISSUES: Maintaining a well-documented medical record is a vital component of proper healthcare delivery. Additionally, it can be one of the most important defense tools in the event of a malpractice case. Documentation issues were a factor in 67% of claims paid in Interventional Pain Management; of those, nearly ¾ involved inadequate documentation, which hindered the defensibility of the care provided. Typically, the problem was a failure to document the following: a complete patient and/or family history; the specific elements of a physical exam; the rationale for the diagnosis and treatment plan; the details of patient education; and the specific content of information exchanged in telephone encounters.

A case illustrating several documentation failures involved a 47-year-old male patient who continued to experience chronic pain following cervical-spine surgery. He underwent an epidural steroid injection at C7-T1 under fluoroscopy. He complained of pain following the procedure but was able to move all extremities. As his wife was transporting him home, he lost feeling in his legs. When his wife called the office to report the loss of feeling, a medical assistant, without the benefit of a Clinical Advice Protocol and without consulting the physician, advised that the patient was experiencing a normal reaction to the injection. Later that afternoon, the patient began experiencing leg spasms and had no feeling from

the nipple line down. The on-call physician instructed the wife to take the patient immediately to the emergency room. At the hospital, he was diagnosed with an epidural hematoma and underwent an immediate decompressive laminectomy. The patient suffered significant neurologic deficits including impaired bladder function, pain, and the inability to walk normally. The following documentation shortcomings gave the impression of sloppy, inattentive care and made it difficult to defend against the plaintiff's allegations of negligence:

- the consent form signed by the patient was generic and did not include any risks specific to an epidural steroid block, and there was no office note detailing that specific risks, benefits or alternatives had been discussed;
- there was no documentation of the post-procedure discussions advising the patient regarding symptoms to report or when to seek immediate follow-up care; and
- neither the first phone call to the office, nor after hours exchange with the on-call physician advising the patient's wife to take him immediately to the emergency department, were documented.

Untimely notes were also a problem in a number of the cases reviewed. In addition to the classic case of a physician creating what appeared as a defensive note days after the procedure and complication occurred, there was one case where the discharge summary was dictated well in advance of the procedure and complication. In that case, the patient experienced a spinal cord infarct resulting in paraplegia, impotence and incontinence following an epidural steroid injection. The fact that the discharge summary was dictated in advance of the complications and had not been updated to reflect the emergency event and complications subjected the entire record to suspicion and criticism as to its veracity. Contemporaneous documentation can greatly assist in the defense of a malpractice case because it inspires trust that the record is an accurate and objective account of what occurred in the course of treatment.

COMMUNICATION ISSUES: Effective communication is essential in establishing trust, building good patient rapport, and in achieving treatment adherence. In the claims reviewed, 45% contained evidence of communication breakdowns, 80% of which involved physician-to-patient communication. The recurrent theme throughout these cases was a failure to provide patients with clear and complete information on their medical situation as well as the risks, benefits, alternatives and expected outcomes associated with the recommended treatment plan.

MEDICATION ISSUES: Medication errors were present in 27% of the cases reviewed and involved administration issues, contraindicated medications, wrong doses and wrong drugs. One case involved a 68-year-old female patient with chronic pain syndrome who underwent reprogramming of her intrathecal pain pump in the office. The anesthesiologist used a hand-held device to change the patient's Fentanyl "demand dosage" from 30 to 35 micrograms. Unfortunately, he inadvertently entered 350 micrograms. The next day the patient's husband called to report that his wife arrested at home and was in the ICU. At that point, the physician printed off the Medtronic form reflecting the reprogramming from

the day before and discovered the error. The patient subsequently suffered anoxic encephalopathy and expired.

LESSONS LEARNED:

- Keep current with the standard of care. When utilizing a controversial technique or medication, note your rationale for doing so in the record.
- In the event of an unexpected or adverse outcome, consider the worst-case scenario in your differential diagnosis.
- Perform a thorough neurological evaluation of the patient and clearly document the findings in the medical record.
- Consult with, or refer the patient to, a neurologist if unsure about the source of the patient's neurological complaints or symptoms.
- Develop and utilize a Triage Protocol to assist telephone response personnel in directing calls to the appropriate staff.
- Develop and utilize Clinical Advice Protocols to assist clinical staff who give patient advice and to clarify when to refer calls to the provider.
- Document timely and completely – including a thorough history, details of the physical examination, diagnosis and treatment rationale (if not self-evident), patient instructions/education and details of telephone calls. Such documentation enhances patient care and bolsters your credibility if called upon to defend such care.
- Review all documentation carefully before signing to ensure it is an accurate representation of the examination or procedure.
- Clearly communicate with patients and ensure an understanding of information relayed when providing medical advice over the telephone. At a minimum, document the following types of phone calls: when reporting test results to patients; when the patient is advised to return to the office or go to the emergency department; and when the patient requests medical advice or prescription refills.
- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits, expected outcome, and alternatives. Doing so not only discharges your legal and ethical obligation to provide patients with sufficient information with which to make an educated election about the course of their medical care, but may also help create realistic expectations on the patient's part as to the outcome of treatment. Be careful not to educate above their comprehension level. Be sure to document the details of all discussions with patients in your office record or on a procedure specific form.
- Provide clear, detailed, understandable and specific written post-procedure instructions to patients – including what signs and symptoms to watch for, the significance of keeping follow-up appointments and what symptoms warrant an immediate visit to the emergency department.
- With regard to pain pumps, print off information on the dose entered at the last visit and the new dose entered after reprogramming the setting and review it with the patient.
- Have someone verify the dose calculation and vial of medication to be injected

along with the printout after a pump refill has been completed.

- To help prevent medication errors in general: Update the medication history at each visit; review and update allergies at every visit and whenever new medications are prescribed; prescribe medications only after reviewing the record; discuss risks, side effects, benefits, and alternatives to prescribed medications; closely monitor high risk medications; train staff who are allowed to administer medications to adhere to the “Five Rights”(right patient, right drug, right dose, right route, right time) and to utilize appropriate injection techniques.
- Follow the CDC recommendations for multi-dose vials and safe practices for medical injections available at this CDC link.
