# Reducing Liability Exposure In the Physician Office

As healthcare has shifted more toward the outpatient setting, the complexity and acuity of patients seen in that setting has intensified. As noted in MGMA's Patient Safety and Quality Advisory Committee White Paper, "While most ambulatory care is less technically complex than inpatient care, it is often logistically more complicated. An episode of ambulatory care often requires communication and coordination among a number of clinicians, laboratories and imaging facilities, as well as the patient and the family, across different sites… Another unique component of ambulatory care is reliance on the patient and/or the patient's family to seek treatment and carry out much of his or her own clinical management." [1]

SVMIC provides on-site risk evaluation services to policyholders, at their request, to help them identify and address the unique risks in the outpatient setting. In our efforts to provide current, pertinent and comprehensive recommendations, SVMIC conducts closed claim analysis to identify primary allegations and contributing factors. In a review of claims with a paid loss in the last 5 years, 42% occurred in an outpatient setting.
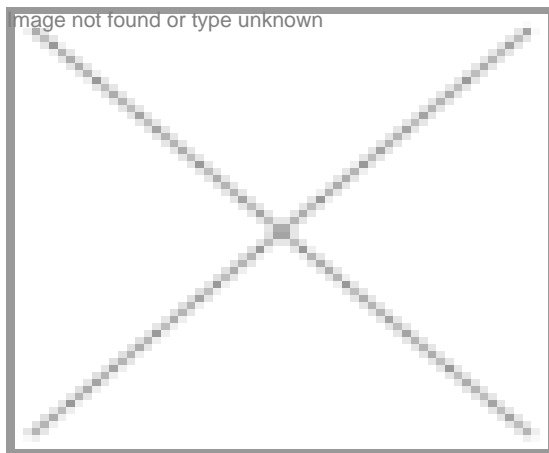
Most Common Allegation

Our data is similar to national data, which reveals that a delay in diagnosis and/or treatment is the number one allegation in the ambulatory setting. As seen in the chart below, 46% of paid closed claims were attributable to diagnostic/management error and 24% were attributable to medication prescribing or management thereof.
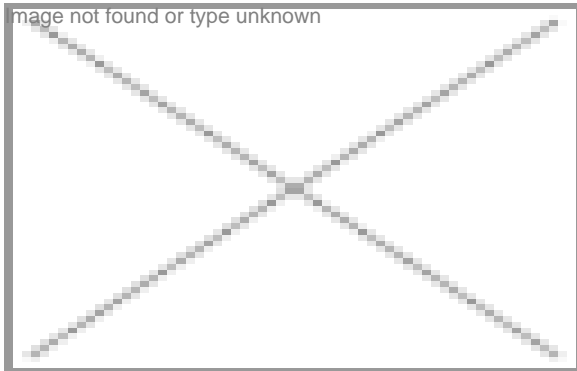
Most Common Contributing Factors

There are multiple national studies which have identified the most commonly occurring errors related to missed diagnosis and delayed treatment, including incomplete medical history and examination, medication management, test ordering and review, delay in treatment of abnormal test results, mishandling of patient requests and information in the record, and suboptimal coordination of care across different healthcare facilities and between providers. [2][3] [4][5][6]

These factors were also present in the closed claim data that we reviewed, which demonstrates that adverse outcomes are often not due to clinical competency issues but rather a breakdown in processes or communication. Such was the case in the following example:

In follow-up to a mom's complaint of "staring spells" during her teenage daughter's well checkup, an EEG was ordered. The mother called the office for results one week after the EEG was performed and was told the results were not back yet. Four days later, the hospital contacted the pediatrician regarding the abnormal results and the pediatrician ordered a neurology consult. The office attempted to call mother to notify her of such. Documentation was limited to "left a voice message for mom to call back". The office did not hear back from the mother and made no further attempts to contact her. Additionally, due to a process breakdown, no referral was arranged. Nine months later, the teenager arrested and resuscitation was unsuccessful. The failure to make additional attempts to contact the mother and failure to follow-up on the referral to neurology hindered the ability to defend the case. The case was settled.

On-site Risk Opportunity Findings:

In the on-site risk evaluation visits, conducted by SVMIC's legal nurse consultants, the focus is on the most significant areas of liability exposure (delay in diagnosis/treatment and medication related errors) and the critical processes that can influence those. The hard part for practices is not motivating physicians and staff to improve patient safety, but rather developing and maintaining consistent systems and processes in the midst of a busy practice.

Most Significant Risk Opportunities Identified In Our Onsite Visits Over the Last Five Years:

1. Close the loop with test results by adopting consistently used tracking systems

The Agency for Healthcare Research and Quality (AHRQ) diagram identifies best practices with ordered tests, i.e. a process that ensures test results have been received and reviewed in a timely manner, communicated to the patient, and follow-up treatment (if indicated) provided, including the documentation thereof. This step-by-step process is known as a "tracking system".

Almost 90% of providers undergoing an on-site risk assessment have a system to track lab and diagnostic test results, most of whom utilize electronic tracking. Those who do not have effective systems in place 1) attempt to rely on memory, 2) have made the assumption that a system is unnecessary based on their experience that tests often return without follow-up or 3) rely on a follow-up visit as the trigger to review test results without being aware of no-shows and cancellations. Likewise, the great majority of providers report reviewing all test results and documenting having done so. Patient notification of test results is essential (as is documentation of the notification), even those that are normal. Most providers reported to us that they notify patients of all test results, including the normal results. They understood the importance of involving the patient in their care

and the additional safety net that patients can provide when told "call if no results received".

2. Improve continuity of care between healthcare facilities and providers

Effective communication is the key to ensuring continuity of care. Many of the specialists we spoke with have a consistent process whereby their staff notifies the referring physician if the patient fails to present for the first appointment. By contrast, our findings revealed that referring providers often do not consistently have a process in place to ensure the consultant's report has been received.

With regard to hospital discharges, most physicians had a mechanism in place to ensure patients had a post-discharge appointment following their hospitalization and understood the possible risk of the patient being "lost" by virtue of the fact that he/she is not within the office confines at the time of discharge.

3. Improve accurate documentation of medication and monitoring

The sheer volume of prescriptions written in the outpatient setting contributes to increased potential for medication- related adverse outcomes. SVMIC data reveals that medication related issues are the second most common claim in the physician office setting. Medication reconciliation between providers and facilities can be especially challenging. Our record review showed the consistent presence of a medication/allergy list. Practice managers typically report that staff takes a medication history at each visit prior to being seen by the provider. Of note, providers infrequently documented the patient's self-reported use of illegal substances or misuse of controlled substances, both of which are important areas to explore with the patient prior to prescribing medications.

While providers reported frequently educating patients about the importance of high-risk or newly prescribed medications, documentation of this was infrequently seen. Practices that frequently prescribe high-risk medications acknowledged the importance of tracking systems to ensure the patient is seen in follow-up and medication is appropriately monitored.

4. Maintain complete, accurate and timely documentation

The importance of maintaining a well-documented medical record cannot be overstated from both a patient care and a risk management standpoint. Inadequate documentation can negatively impact the ability to defend the care provided to a patient.

Our record review revealed the following elements to be frequently present: complete medical history, allergy/medication list, physical exam, and diagnosis/treatment plan. Specific recommendations for screening tests were not consistently present. A procedure consent discussion was usually documented within the office note; documentation ranged from "risks and benefits discussed" to a comprehensive listing of the more common and most serious risks, even if rare.

With the steady adoption of EHR over the last five years, associated risks have risen including templated notes that may not reflect the clinical picture or clearly describe the treatment plan. Additionally, timeliness of note completion within 48 hours has been challenging for some providers. While staff typically reported documentation of all phone calls in which clinical information was exchanged, the documentation of these patient calls was often nondescript such as "called patient" or "left message". Many providers indicated that they documented only "the most important" after hour phone calls or in some cases, did not document them at all.

Keep in mind that good documentation is the best defense against liability should a complication arise. Absent or incomplete documentation can seriously undermine efforts to defend the medical care if a lawsuit is filed.

Action You Can Take Now To Address The Most Significant Exposures:

- Providers and practice managers should promote a culture of safety and teamwork. Educate staff on their role in improving patient safety.
- Evaluate all of your tracking systems for effectiveness and consistent use by all providers. Track all tests from all facilities/lab vendors, not just those that interface with your EHR.
- Notify patients of all test results. Instruct them to call you if they have not received the results within a specified time period.
- Consistently follow up on referrals. If you are a specialist, notify the referring physician if the patient does not present. If you are the referring physician, follow-up to obtain the results from the consultant.
- Document the patient's full medical history, including social habits. Prioritize accurate documentation of medications. Train staff to take medication history with every visit and to avoid yes/no questions, such as "are all your medications the same?"
- When first initiating high-risk medication therapy, educate the patient to understand the indications for the medication, the potential risks and benefits, potential side effects and how to manage them. Consider using medication educational modules in your EHR or resources such as the one here. Document your education efforts in the medical record.
- Refer to the Electronic Health Record Self-Assessment at on our site to assist with the identification of EHR risks within your practice.
- Use the informed consent process as another opportunity to establish or solidify rapport. Provide the patient with adequate opportunity to ask questions. While the

most serious risks for a procedure may be rare, it's important to include those in your discussion and documentation as well.

- Take the time to document all calls in which clinical information is exchanged, including who you spoke with and what information/instructions were given. SVMIC after-hour phone call pads are available at no charge. Additionally, technology is now available that can assist physicians in documenting phone calls after hours with encrypted software on mobile phones.
- To learn more about tracking and EHR documentation, The SVMIC Education Center to attend online courses, which are available for providers and staff.

If you would like a personalized risk evaluation of your practice, contact SVMIC and ask to speak with Risk Evaluation Services.

[1] Meeting the Challenge of Patient Safety in the Ambulatory Care Setting. Medical Group Management Association. Patient safety and Quality Advisory Committee White Paper. Available at : https://www.mgma.com/practice-resources/topics-overview/meeting-the-challenge-of-patient-safety-in-the-ambulatory-care-setting

[2]Hardeep Singh, MD, MPH; Traber Davis Giardina, MA, MSW; Ashley N. D. Meyer, PhD; et al. Types and Origins of Diagnostic Errors in Primary Care Settings. JAMA Intern Med. 2013;173(6):418-425. doi:10.1001/jamainternmed.2013.2777

[3] Woolf SH1, Kuzel AJ, Dovey SM, Phillips RL Jr. A string of mistakes: the importance of cascade analysis in describing, counting, and preventing medical errors. Ann Fam Med. 2004 Jul-Aug;2(4):317-26.

[4] John S. Webster, MD, MBA, Heidi B. King, MS, CHE, Lauren M. Toomey, RN, BSBA, MIS, Mary L. Salisbury, RN, MSN, Stephen M. Powell, BA, ASO, Brigetta Craft, RN, MSN, DNP, David P. Baker, PhD, and Eduardo Salas, PhD. Understanding Quality and Safety Problems in the Ambulatory Environment: Seeking Improvement With Promising Teamwork Tools and Strategies. Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 3: Performance and Tools).

[5] American College of Physicians. Patient Safety in the Office-Based Practice Setting. Philadelphia: American College of Physicians; 2017: Position Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

[6] Casalino LP1, Dunham D, Chin MH, Bielang R, Kistner EO, Karrison TG, Ong MK, Sarkar U, McLaughlin MA, Meltzer DO. Frequency of failure to inform patients of clinically significant outpatient test results. Arch Intern Med. 2009 Jun 22;169(12):1123-9. doi: 10.1001/archinternmed.2009.130.

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