When Instincts are Ignored

By William "Mike" J. Johnson, JD

Our instincts of self-preservation and “common sense” protect us from many hazards. This article illustrates what can happen when those instincts are absent or ignored.

The plaintiff, a middle-aged diabetic female, presented to a family practice physician for the primary purpose of obtaining medication for her diabetes. This was her very first time to visit this practice and this physician. During the visit, she also asked the physician to examine a small, pimple-type lesion on her buttock. She was diagnosed with cellulitis, skin ulceration, skin abscess and diabetes. Neither a culture of the lesion nor a blood sugar level were obtained. She was prescribed Bactrim, Silvadene and medications for diabetes and pain. She was scheduled for follow-up in fourteen days and told to return if the lesion worsened.

The communications that took place during those fourteen days are disputed between the physician, the office staff, the patient and her husband. The husband says he spoke with the physician and told him her condition was worsening and that she was out of antibiotics and pain pills. According to the husband, the physician refused to treat her. The physician maintained his only communication with the husband was related to giving a refill of pain medication. The physician’s staff denied that the patient called requesting either an earlier appointment or to advise the physician that her condition was worsening.

When the patient presented for the two-week follow-up, she had extensive areas of gangrene affecting the gluteal area. She was emergently admitted to the hospital where she underwent surgical debridement and began a lengthy course of treatment, including a diverting colostomy. The patient and her husband sued the family practice physician. The complaint alleged that the physician failed to properly diagnose the patient’s condition, failed to obtain a culture or blood sample, failed to re-examine the patient sooner and failed to prescribe additional antibiotics.

In this case, the patient presented with a small skin infection that progressed to a life or limb-threatening gangrenous infection, yet neither she nor her husband made any meaningful effort to secure medical help from this physician or any other medical provider. Her husband agreed that the wound increased in size and severity and emitted a putrid odor. He went so far as to purchase a walker for her as the infection made ambulation difficult. The most basic and routine biological functions were compromised due to the location of the infection and may have exacerbated the infection. She had to be transported on her side to the scheduled appointment, as she could not sit in the vehicle. The patient denied any responsibility for neglect of her own medical condition and

explained that she “trusted” the physician and did not see a need in going elsewhere for medical care. Incredibly, the patient stated that after the first office visit she did not look at the wound again.

We may never know why the plaintiffs failed to get medical help in the face of such a horrifically deteriorating condition. Did the physician have any warning signs of her deteriorating condition? Possibly the request for more pain medication signaled that the infection was not improving. The physician maintained that he had no idea that the patient’s condition deteriorated to this extent.

While it is more common that a patient may neglect a latent, subtle or hidden condition, in rare circumstances patients may neglect their own care when the danger, as here, is obvious. Under similar circumstances, we offer some risk prevention suggestions:

- Clear, easy-to-understand documented instructions help protect the patient and the physician. Is there a particular risk that merits a special warning? Here, the patient was more susceptible to a worsening infection due to her diabetes and the location of the infection.
- Does a patient’s concern over cost cause the patient to refuse certain tests or make a patient reluctant to obtain follow-up appointments? If so, consider getting the patient to execute a Refusal of Treatment form (available here) or make other appropriate documentation.
- What does the “new” patient’s history tell you about the patient? Is the patient reliable? Who was the previous physician? Why is the patient no longer going to the previous physician? Is the patient seeking your full care and expertise or coming to you only to get a prescription or for treatment of a specific problem?

Lawsuits often involve disputed allegations concerning communications with the physician’s office. In your practice, are all calls documented? Is advice given by phone being reviewed and authorized by the physician? Are after-hours calls and calls received and made by a covering physician being documented? Some elements of this documentation should include:

- The date and time of the call.
- The direction of the call (the patient calling in or the physician’s office calling the patient).
- The names of those involved in the call.
- The nature of the call, and any orders, instructions, or information given.

Thorough documentation that supports the physician’s appropriate medical care may help to head off a lawsuit in the event the patient’s instincts of self-preservation are simply not what they should be. In fact, in any medical malpractice case, good documentation can only increase the chance of successfully defending your care.

At trial, this physician received a defense verdict. The jury concluded that the physician and his staff were credible and that their actions in caring for the patient were appropriate.

The One Thousand Dollar Ransom Request

By

The following article is based upon an actual claim situation experienced by an SVMIC policyholder. The details have been altered to protect our policyholder's privacy.

When Mandy*, the receptionist at the small rural medical practice of Dr. Smith, saw that the message light on the phone was blinking, it was not unusual. The practice voicemail was set up with instructions for an emergency, but provided an option to leave a message for routine calls, such as an appointment or prescription refills. However, what Mandy heard on the recording that morning was not a patient, as she anticipated. The electronically disguised voice on the other end of the line informed her the practice's server had been encrypted, the records were being held for ransom and provided instructions to pay the $1,000.00 to unencrypt the records. Mandy saved the message and immediately notified the practice administrator.

Unfortunately, this scenario has become all too common in medical practices. NAS Insurance, our partner in cybersecurity insurance, reported in their June 2017 edition of the Cyber Claims Digest that the company experienced a significant increase in claims activity related to ransomware events during 2016. NAS reported that in 2016, the number of "healthcare-related ransomware events doubled over 2015 activity." You can find this report here.

Fortunately, for this practice, Dr. Smith's professional liability insurance policy with SVMIC includes $50,000 of cybersecurity insurance. The practice administrator called SVMIC claims department, and the report was forwarded to NAS.

A forensic investigator determined that the breach involved only the server that held the images of the old paper files that were scanned when the practice transitioned to electronic health records (EHR), and not their main EHR system. The files on this server were not used very often by the practice and is the reason that they were unaware of the breach until the message was retrieved from their voicemail system. Thankfully, this server, along with all of their other records, was backed up regularly and the practice was able to restore the records without paying the ransom.

However, restoring data is only part of the necessary process after a ransomware attack. A ransomware fact sheet issued by The Department of Health and Human Services (HHS) requires the following regarding a ransomware event: "Unless the covered entity or

business associate can demonstrate that there is a '…low probability that the PHI has been compromised,' …a breach of PHI is presumed to have occurred. The entity must then comply with the applicable breach notification provisions, including notification to affected individuals without unreasonable delay, to the Secretary of HHS, and to the media …in accordance with HIPAA breach notification requirements." You can find the fact sheet here.

This HHS fact sheet further describes what steps a covered entity should take in order "to demonstrate that there is a low probability that the protected health information (PHI) has been compromised because of a breach." HHS says that "a risk assessment considering at least the following four factors …must be conducted: 1. the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; 2. the unauthorized person who used the PHI or to whom the disclosure was made; 3. whether the PHI was actually acquired or viewed; and 4. the extent to which the risk to the PHI has been mitigated."

The good news for Dr. Smith was that the IT forensic expert was able to meet the requirements set forth by HHS to show that it was unlikely that the PHI had been compromised. This story has a successful conclusion because he had been backing up his data nightly, and he had SVMIC's included cybersecurity protection. However, if it had been discovered that Dr. Smith's patients' data had been accessed and compromised, the notification and monitoring costs along with the potential fines and penalties may have exceeded the limits included within his SVMIC policy.

SVMIC has partnered with NAS to bring our policyholders access to NAS cyberNET, a new extensive online resource. This portal offers tools, resources, videos, policies and access to cybersecurity experts. This portal is available here on our cybersecurity resources page. In addition, SVMIC's Medical Practice Services offers consulting and training related to cybersecurity and HIPAA.

* All names have been changed

Safe Medication Practices in the Physician Office

By Julie Loomis, RN, JD

It might surprise you to learn that in the five-year period from 2013-2017, twenty-four percent, or roughly one-fourth, of SVMIC's paid closed claims in physician offices were attributable to errors in medication prescribing or management thereof.

Medication errors encompass all mistakes involving prescription drugs, over-the-counter products, vitamins, minerals, or herbal supplements; however, the overwhelming majority of errors involve the wrong drug or the wrong dose. The categories of error seen in SVMIC claims:

- Prescribing variance (5 R's- right: patient, drug, dose, route, time)
- Addiction related to prescribed drugs
- Contraindicated drugs
- Prescription of drug despite documented allergy
- Injection-related injury (includes IV related injury)
- Drug reaction/side effects/toxicity (overdoses)
- Refusal to prescribe medication

Errors occur at every stage, from medication verification, to ordering, administration and monitoring of the patient's response. Accurately managing your patients' medications can be a complex and difficult responsibility; however, there are some useful risk management practices that can help prevent errors and protect patients. Although the focus of this article is on safe medication practices in the outpatient setting, remember that effective communication is the key to ensuring continuity of care in any setting. This is especially important during transitions of care such as handoffs and hospital discharges. Physicians should have a mechanism in place to ensure patients have a post-discharge appointment following their hospitalization and understand the treatment plan, including medications.

The sheer volume of prescriptions written in the outpatient setting contributes to an increased potential for medication-related adverse outcomes. Medication-related injuries may seem inevitable. However, injuries due to errors in medication prescribing, dispensing and administration are preventable. A medication error is "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer," according to the National Coordinating Council[1] for Medication Error Reporting and Prevention. The council, a group of more than 20 national organizations, including the FDA, examines and evaluates

medication errors and recommends strategies for error prevention.

High-Alert Medication Use

In 1995, the FDA established the black box warning (BBW) system to alert prescribers to drugs with increased risks for patients. These warnings are intended to be the strongest labeling requirement for drugs or drug products that can have serious adverse reactions or potential safety hazards, especially those that may result in death or serious injury. The most common type of warning is issued when there is a potentially serious adverse effect that must be carefully weighed against the potential benefit of the drug. Warnings are also issued to draw attention to dosing, monitoring requirements, and potential drug interactions. Ultimately, physicians must decide whether to prescribe drugs with boxed warnings. In addition to medications with an actual black box warning label, the Institute of Safe Medicine Practices (ISMP) has compiled a list of 14 high-alert medications, as well as a list of 19 high-alert drug classes/categories, which can be found online here. Practices should identify a list of "high-alert" medications that require extra precautions when administered, prescribed or dispensed. High-alert medications are those that have a propensity to cause serious patient harm when used in error. Drugs such as Coumadin (Warfarin) are particularly risky because of a narrow therapeutic index and complex pharmacology. Mistakes in dosing or insufficient monitoring of high-risk medications can lead to serious complications and adverse health effects.

Medication Reconciliation

What can be done to reduce the risk in your practice? The entire medication reconciliation process is critically important. Patients should be asked about their current medications at every encounter, not just every visit. The medication name, dosage, frequency and any adverse effects or intolerances should be updated. Ask if the patient has been treated by any other provider since the last visit and specifically inquire about any new or changed medications.

First and foremost, verify patient allergies at each and every encounter. While this may seem oversimplified, it is often a neglected step in the medication process. Your practice should have a protocol that requires a clinical staff member to ask about allergies and reactions to medications, latex and food (e.g., egg allergies for some vaccines) before any prescriptions, samples or office-administered medications are given to the patient. Document the information in a prominent place that is consistently followed by everyone in the practice. For example, on the medication list, on the top of each progress note page or in a prominent place in your electronic medical record.

Unfortunately, many healthcare workers are pressed for time and have fallen into the habit of reviewing medications by asking simple yes/no questions, such as “are all your medications the same?” It’s not enough to just quickly review what’s already in the record. Consider updating your medication reconciliation template to include 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. Although it will

take a little extra time, asking the patient about any new medications, over-the-counter medications or dosage changes pays off in the long run.

Establish Protocols

Have you taken a look at your protocols for prescription medications lately? Updating medication lists, managing renewals, protection of prescription pads, and maintaining drug samples are all processes that require routine evaluation. The goal of successful medication management is to implement protocols that are followed consistently to prevent errors. Staff members should not renew medications without specific provider approval.

Medication management can be quite complicated, so when medication information is obtained from any source, whether it's a phone call, an office visit, hospital or consultant record, your office should establish a protocol to ensure your team appropriately handles the information every time. Your protocol should meet patient safety goals, be consistently followed and periodically revisited. Educate all staff on the intention behind the protocol so he or she will have a better understanding of the potential for harm when protocols are not followed. Without a standardized protocol for medication reconciliation, the reliability of the information recorded is variable and prone to error.

Tips for Reducing Risk

Safe medication practices in physician offices include many simple, low-cost system changes. The key strategies include simplifying and standardizing your systems related to medications. Processes that are cumbersome and inconsistent often lead to increased risk and error.

- Provide patients with clear instructions about medications at the end of the visit by using a visit summary or other discharge summary.
- Ensure tracking systems are in place so the patient is seen in follow-up and medication is appropriately monitored.
- Document any informed consent discussions, particularly when prescribing a high-risk medication. Determining which risks to discuss within the consent process should be based on the severity of the potential harm, the likelihood of occurrence, and the relevance to the patient.
- Keep patient education materials available for medications and document their use in the chart.
- Encourage patients to carry a current list of medications, including OTC and supplements at all times and to bring them to every visit.
- Remind patients to discard expired or unused medications that have been discontinued.
- Educate patients on the use of their medication, including the indication, side effects, potential for abuse and any required testing or follow up.
- Ask patients to use one pharmacy for all of their prescriptions.
- Improve continuity of care between healthcare facilities and providers.

- Improve accurate documentation of medication and monitoring.

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.

Other Risk Management Strategies

Other risk management strategies to ensure safe medication practices include the following:

- Evaluate your patient's medical literacy. Don't take for granted that your patients are as familiar with medical information as you are.
- Separate problematic (such as high-risk or sound-alike) medications from your sample or storage areas and control access to medications. Organize the sample closet by classification rather than alphabetically.
- Pay attention to EHR alerts and other clinical decision support tools.
- Utilize medication educational modules in your EHR or resources, including reminders for serial testing.
- Make certain all medication orders are complete and include the correct drug name, dosage, frequency, indication and refills if approved.
- Watch out for look-alike or sound-alike medications.
- Avoid confusing or non-standard abbreviations.
- Be sure to ask patients about any medication side effect or intolerance at every visit.

- Document the patient's full medical history, including social habits.
- Take the time to document **all** calls in which clinical information is exchanged, including with whom you spoke and the information or instructions given. SVMIC after-hour phone call pads are available here at no charge. Additionally, technology is now available that can assist physicians in documenting phone calls after hours with encrypted software on mobile phones.

Safe medication practices benefit everyone along the healthcare continuum and should be easy to identify and implement in your medical office. The key is to have well-organized records, consistent policies, well-trained staff and educated patients so preventable medication errors are a rare occurrence.

[1] http://www.nccmerp.org

Avoid Drifting into Unsafe Habits

By Julie Loomis, RN, JD

Have you or your staff been “drifting into unsafe habits?” Do you follow the template generated by your EHR without questioning its validity or applicability to the patient in front of you? Do you ignore alerts and other prompts? Do you ask only close-ended questions of patients such as, “Are all of your medications still the same?” If you answered yes to any of these questions, you could be drifting into unsafe habits and putting your patients at higher risk of harm.

According to The Institute of Safe Medicine Practices[1], behavioral research shows that we are programmed to drift into unsafe habits, to lose perception of the risk attached to everyday behaviors, or mistakenly believe the risk to be justified. In general, workers are most concerned with the immediate and certain consequences of their behavior—saved time, for example—and undervalue delayed or uncertain consequences, such as patient harm. Their decisions about what is important on a daily list of tasks are based on the immediate desired outcomes. Over time, as perceptions of risk fade away and workers try to do more with less, they may tend to take shortcuts and drift away from behaviors they know are safer.

Simply ask yourself “why” you do it this way? Why is this policy in place? It’s important that policies are consistently followed and periodically revisited. Educate all staff on the intention behind the policy so he or she will have a better understanding of the potential for harm when policies are not followed.

Although it will take a little extra time, increasing your attention to detail and evaluating areas where you could be missing opportunities to provide safer care will pay off in the long run.

[1] http://www.ismp.org/newsletters/acutecare/articles/20060921.asp

Managing the Challenges of Technology

By Elizabeth Woodcock, MBA, FACMPE, CPC

Electronic health record (EHR) systems are installed in most practices, yet they remain the source of daily headaches. Having worked in practice management for many years, my philosophy is that the systems were built by technology experts, not those familiar with the workflow of a physician's office. While the systems are undoubtedly improving over time, there are some steps that you can take now to avoid the 'EHR blues'.

Integrate quality reporting into staff workflow. In order to comply with Medicare's Quality Payment Program (QPP), a series of data must be reported. Small practices – as defined by the federal government, 15 clinicians or less – can file for an automatic exemption from reporting the advancing care information category simply based on practice size as of the 2018 reporting year. However, the quality measures must still be tracked. Consider choosing the straightforward ones that your support staff can take charge of – such as BMI or asking patients whether they had their flu vaccine. It's often overlooked that these general medicine metrics can be reported by any specialty, while still fulfilling the requirements of the QPP.

Hire a scribe. If typing isn't in your skill set, do not despair. Scribes – specially trained, or those you train yourself – can be hired to document for you. In general, scribes pay for themselves at two patients a day. Because the vast majority of your costs are fixed, those two additional visits fall directly to the bottom line. At $100 per visit, two days a week in a 48-week work year, those extra encounters equate to nearly $50,000 for a physician working five days a week. Changing the assumptions alters the financial pro forma, but most physicians can still come out neutral with the two-extra-per-day model.

Prep for the visit. Remember the days of eyeballing the paper record before the patient arrived? Do the same for patients today, by yourself – or assigning the task to your support staff. With sensitivity to documentation requirements, get the chart 'ready' by moving over data from the previous visit, to include tests you may have ordered after the encounter. Carefully review the information carried over from the previous visit and validate for accuracy/relevancy before signing your note.

Make the EHR system work for you. Although an EHR system may never be at the center of your ideal workflow, there are strategies to improve its impact on your efficiency. Put your laptop or computer on a workstation on wheels, ideally with a basic printer situated on a shelf on the workstation. As timesavers, keep a stamp with your address

handy for patients' forms, as well as a folder with paperwork that you commonly produce (e.g., directions to your imaging center). Set up the e-fax functionality to receive and transmit faxes electronically. Consider integrating precertification forms into your EHR to auto populate, and/or use a free service like CoverMyMeds.com to extract data to facilitate medication pre-authorizations. Finally, always use the EHR system's functionality related to 'smart phrases' - as well as related enhancements like order sets - to save you time.

Electronic health record systems may not provide the benefits you were promised, but don't let them keep you up at night. Now that you've had a year – or a few – working with one, take the opportunity to review, analyze – and update – how you use your system.

Managing Your Schedule is Vital to a Successful Practice

By Elizabeth Woodcock, MBA, FACMPE, CPC

Of the many ways that a manager can contribute to a practice's success, the ability to manage the physicians' time is the most important. The time of your physicians, advanced practice providers and other billable providers is, ultimately, your practice's most valuable asset. In addition to a revenue opportunity, billable time — the direct contact with a physician or other provider — is exactly what patients want.

The key to maximizing billable time is to proactively manage the schedule. There's more to it than just dividing each hour of the clinical work day into slots for patient appointments and then filling them. Smart strategies to get the most out of the schedule may include predictive booking – smart overbooking, in other words. For example, it may be possible to book a well-woman physical that requires initial nursing time alongside an established patient with an acute problem. Once you complete the established patient encounter, the patient who has presented for the well-woman exam will be ready for the practice professional.

The strategies change according to specialty, of course. If you're managing a surgical practice, it's vital to take your surgical yield into consideration when constructing your schedule. If you want 8 cases a week, but your surgical yield is 50 percent of all new patients, then you need to book at least 16 new patients in your office schedule. Of course, you'll also want to account for your scheduled-but-not-arrived rate by adding a handful more, to cover no-shows and cancellations. Apply this same concept to your practice, switching out the "surgical yield" for your desired outcome.

The math is simple, but these basic scheduling concepts are business critical for successful medical practices.

What Kind of "Manager" Does Your Practice Need?

By Elizabeth Woodcock, MBA, FACMPE, CPC

Don’t start looking for someone to run your office until you know what the person in this position must do. While many of the qualities needed in a successful manager are universal — solution-oriented, delegator, motivator, etc. — more depend on your office’s unique needs.

It might seem like a needless exercise, but settling on the position’s title is an important first step. Advertising for a “Practice Administrator” is likely to draw candidates with deeper education and experience than those seeking a position as “Office Supervisor.”

The title itself may connotate certain duties: “Office Manager” says this person runs your office, while “Practice Manager” indicates a person who is more deeply involved in the services you perform at hospitals, surgery centers, and other locations as well as your office. Larger practices often opt to call this person their “Administrator” or even “Executive Director.” When the lead physician retains the Chief Executive Officer role, the manager’s role could be best expressed by the title, “Chief Operating Officer.”

If you are not a part of a health system, hospital, or corporate structure, then the person you select as manager must be able to handle a wide range of key practice functions: compliance, contracting, operations, human resources, facility management, billing and finances. Some of these duties may be delegated; however, the office manager is typically held accountable for the people carrying out these efforts. Within a corporate structure, the person commonly manages the personnel and operations at the office, with responsibility for coordinating the administrative activities that are carried out by the system.

Determining the proper job title should be accompanied by a clear list of the position’s responsibilities and accountabilities. It’s all part of getting the best person in the right role. It may be the greatest investment you can make to ensure that your practice runs smoothly – and successfully.
