Summary Judgment Saves the Day

By Tim Rector, JD, MBA

Mary is a 60-year-old female who brought suit against a cardiologist alleging he failed to timely diagnose and treat her retroperitoneal hemorrhage following a cardiac catheterization. Unfortunately, for Mary, this alleged failure to diagnose and treat her resulted in a cascade of multiple medical/surgical conditions.

Mary arrived at the emergency department of a rural hospital on June 1 with complaints of chest pain, numbness, 9 of 10 pain in her left arm, shortness of breath, and diaphoresis. Mary had a prior history of hypertension, emphysema, atrial fibrillation, Coumadin therapy, prosthetic valve replacement, high cholesterol, and a heart catheterization two years prior. Mary was diagnosed with acute myocardial infarction (MI) and was given a heparin bolus and drip, Retavase, and Lopressor.

Mary was transferred to a larger hospital where she was taken for emergency left heart catheterization with coronary angiography which showed severe three vessel disease. Angioplasty was not performed because it was felt that Mary would be best served by a coronary artery bypass graft. The sheath was pulled with manual pressure applied for 25 minutes; hemostasis was noted. Heparin was restarted, and documentation in the nursing notes indicated several times that her groin site was without complication. An echocardiogram revealed an ejection fraction of 40-45% with inferior hypokinesis, mild to moderate mitral and tricuspid regurgitation, and a right ventricle systolic pressure measurement of 40-50 mm suggesting pulmonary hypertension. The CABG procedure was planned for the following week to allow Mary time to recover from her acute MI. The plan was to keep Mary on heparin while she was off Coumadin. On June 2, Mary complained of back pain. On June 3, she was noted to be hypotensive and complained of right groin pain. The cardiologist ordered discontinuation of the heparin drip, and an IV fluid bolus was given (normal hemoglobin of 14 and hematocrit of 41). The following day, June 4, the heparin drip was restarted. By June 7, Mary's hematocrit dropped to 24.8 (normal range 34.9-44.5) so she was transfused with red blood cells. Mary continued to complain of back pain and developed a decrease in urinary output with a WBC of 31,000 (normal range 3,500 to 10,500). On June 9, a CT of the abdomen reveraled a retroperitoneal hematoma compressing the bladder and rectum.

That day, a general surgeon recommended holding heparin for 12 hours with transfusion of packed red blood cells. The surgeon determined that Mary was not a good surgical candidate due to the recent MI. On June 10, the heparin drip was restarted and a renal consult was obtained due to worsening renal insufficiency. Over the next few days, Mary's condition gradually improved. However, her condition deteriorated on June 17 when she

developed hematuria and bloody diarrhea. A GI consult was obtained as well as a tagged red blood cell study, which revealed no evidence of bleeding. Her heparin drip was discontinued. An EGD showed a duodenal ulcer. On June 18, Mary developed a colovaginal fistula and underwent an exploratory laparotomy with colostomy and sigmoidectomy; the pathology report showed acute necrotizing colitis. She next developed a right pleural effusion requiring chest tube placement on June 28. Mary was ultimately discharged on July 8 with follow-up on her Coumadin, beta blocker and statin therapy, as well as physical therapy. On August 8, she was able to ambulate with a walker. A cystoscopy subsequently showed a vesicovaginal fistula and enterovaginal fistula. These conditions prompted the cardiologist to transfer Mary to a larger cardiology group practicing at a tertiary hospital that could provide her with more specialized care. Here, Mary underwent treatment for the fistulas including the new condition of pyelonephritis. In November, a cardio stress test showed no evidence of ischemia, so Mary was deemed an appropriate candidate for surgery for her cystectomy and ileal conduit, and a proctectomy that occurred four months later. During litigation, Mary did not yet have the CABG procedure."

What did the experts say after Mary filed her lawsuit? There was no real debate that the combination of Retavase, aspirin, Coumadin, and intravenous heparin likely contributed to the retroperitoneal hematoma. Retroperitoneal bleeding is a known, albeit relatively rare, complication of a cardiac catheterization. When the general surgeon was consulted, she believed that Mary was an inappropriate surgical candidate given her recent MI. Therefore, plaintiff's counsel argument that an earlier CT would have made a difference was a red herring. The debatable issue came down to a matter of opinion as to whether or not her heparin should have been discontinued and for how long.

The plaintiff's only expert on standard of care and causation was a cardiovascular surgeon, whose deposition testimony contained several mistakes that damaged the plaintiff's case. He stated he did not consider himself an expert in cardiology and, more importantly, he had no experience in dealing with fistulas, conditions involving vaginal and bladder ischemia, although he opined these were complications of the hematoma and could have been prevented. Based on these statements, the trial court excluded the plaintiff's expert from testifying on causation since his opinions lacked reliability. The expert was simply ill-prepared to give a deposition. As a result, our cardiologist was granted a summary judgment by the trial judge, thus ending the case. But for the summary judgment, this was a case that could have gone badly for the physician at trial, especially if Mary had a colostomy and was dependent upon a walker in the court room. The lesson learned here is to take seriously the preparation efforts in answering discovery or the giving of a deposition during the litigation process.

For 2017: $7 Million Dividend, No Rate Increases

The Board of Directors of SVMIC is pleased to announce a $7 million dividend for policyholders again this year. This amounts to approximately 5.5% of annual premiums. SVMIC has now issued dividends in 33 of its 41 years in business. Further, the Board has decided to keep premium rates unchanged for 2017. SVMIC has not had a rate increase since 2008; when adjusted for inflation, average premiums now are nearly the lowest in the history of your company.

Just Say Yes to MIPS Participation in 2017

By Elizabeth Woodcock, MBA, FACMPE, CPC

January 1, 2017, marked the commencement of the Quality Payment Program (QPP). The government's initiative is mandated for physicians and other eligible clinicians who provide care for Medicare patients. By 2019, non-participation fines will be up to 4% of Medicare payments, so it is important to enroll now. The QPP offers two tracks to participate – joining an Advanced Alternative Payment Model (APM) or reporting the elements required for the Merit-based Incentive Payment System (MIPS). Since Advanced APMs are difficult to find, even for those who would like to join, the vast majority of clinicians are participating in MIPS in the initial year of the program. Since the reporting year began on January 1, what action steps should you take today?

The first step is to determine your eligibility. A significant portion of physicians and other eligible clinicians – 35%, based on the government's estimates – need not be concerned with the QPP. If you bill less than $30,000 in total allowed Medicare Part B charges, see less than 100 Medicare patients, or are in your first year of practice - then there is no need to participate in the QPP. The government has promised a resource at which you can query your inclusion, but that has yet to launch. Until then, examine your practice management reports to determine your eligibility.

If you choose to take the MIPS path instead of the Advanced APM path, you can choose to submit **one** of the following:

1) One Quality measure, all of the base Advanced Care Information (ACI) criteria, or one of the Improvement Activities to simply avoid a penalty, or

2) More than one measure – but not all of them for a potential small increase in payments, or

3) Full participation; this includes six Quality measures, all of the base ACI criteria plus the additional ACI requirements which add up to 100 points, as well as two to four Improvement Activities, depending on practice size for a larger incentive.

The first option is not only the easiest one, but it requires only three letters: "YES." The easiest route to eliminating the 4% reduction in your Medicare payments in 2019 - the first "adjustment" year of the program – is to declare your engagement in one of the Improvement Activities. This won't be a difficult exercise, as there are 92 Improvement

Activities from which to choose. The list includes: regular training in care coordination; timely communication of test results; and collection of patient experience and satisfaction data on access to care and development of an improvement plan. Click here for the complete set of Improvement Activities.

The list doesn't end there - seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare – is also one of the activities. Therefore, if you see Medicaid patients – and/or those with Medicare/Medicaid coverage – you can submit a positive response for MIPS, and avoid all penalties.

If you want to participate in full, it pays to aim high. You will want to position yourself to gain 70 points, as that's the number needed to reach the threshold to qualify for the "exceptional" performance. Achieving this mark means that you are in the running for a bonus of up to 12% of all Medicare reimbursement. Don't sweat it if you haven't already started; despite the fact that the government's material speaks to the reporting *year*, submitting any consecutive 90-day period in 2017 equates to full participation in MIPS.

Regardless of the "pace" you choose, data submission isn't yet available. Indeed, it will likely be early next year before you can report your 2017 performance. Picking your option today, however, means that you can be prepared to submit the data in accordance with program requirements – whether it be a simple "YES" – or collecting the 20-plus elements required for full participation.

MIPS - Isn't This Program Being Repealed?

Many physicians and practice executives are under the impression that the Merit-based Incentive Payment System (MIPS) is being eliminated. The assumption results from the likely repeal of the Affordable Care Act, also known as "ObamaCare." It's important to recognize that MIPS is a product of another law – the Medicare Access to Care and CHIP Reauthorization Act (MACRA). MACRA became law in April 2015 with overwhelming support from Republicans and Democrats. In addition to its bicameral support, the law only pertains to physicians and other eligible clinicians. The law does not impact hospitals, nursing homes, ambulatory surgery centers, etc. Given the history of its passage and lacking other stakeholders to exert pressure on lawmakers, it is doubtful that MACRA will be overturned.

Changes to Medicare "Incident To" Billing Requirements

By Jackie Boswell, FACMPE

Medicare allows a physician to bill for certain services furnished by an Advanced Practice Practitioner (APP) under what is referred to as "incident to" billing. The "incident to" rule permits services furnished as an integral part of the physician's professional services in the course of diagnosis or treatment of an injury or illness to be reimbursed at 100% of the physician fee schedule, even if the service is not directly furnished by the physician. (A requirement of “incident to” billing is that the physician must have had an initial face-to-face encounter with the patient, which means “incident to” does not apply if the APP sees a new patient or an established patient with a new problem.)

A significant requirement for the services of APPs to be billed as "incident to" is direct supervision by the physician. Although the supervising physician does not need to be present in the room where the APP is seeing the patient, the “direct supervision” standard requires the supervising physician be “physically present in the office suite and immediately available to furnish assistance and direction” during the time the APP is providing the service.

The 2016 Medicare physician payment rule provides some clarification on how the direct supervision requirement under the “incident to” billing rules operates. The new rule clarifies that the physician who directly supervises the APP is the only party that can bill the service of the APP as “incident to” his or her service. CMS considers this as a clarification of its longstanding policy, but many providers will see this as a new restriction of the “incident to” guidelines.

This clarification will cause consternation in some practices, because often more than one physician (in the same practice) will be involved in the care of a patient. It is common for one physician to visit the patient and order a test or procedure, and then have the APP follow-up with the patient for that particular diagnosis. A different physician may supervise some of the follow-up visits. Prior to this clarification, the physician who originally ordered the service might have billed the APPs follow-up as "incident to" (under his/her billing number) even though another physician actually supervised the performance of the service. The revised regulatory language clarified this is not permitted, and that only the physician actually present in the office suite who supervises the service can bill for the service as "incident to" his or her service. When filing a claim for services billed "incident to" a physician's services, the billing number of the physician that actually supervises the performance of the service must be used rather than that of the ordering physician.

According to CMS, the reason behind this rule is that "billing practitioners should have a personal role in, and responsibility for, furnishing services for which they are billing and receiving payment as an incident to their own professional service." In view of this regulatory clarification, physician practices may wish to reexamine their billing process and procedures to clarify the correct billing for "incident to" services. They should also insure that physicians and staff are trained on the proper supervision and billing of services under the "incident to" rules.

Handling Difficult Situations

By Elizabeth Woodcock, MBA, FACMPE, CPC

When you work in a medical practice, you face challenging situations every day. Particularly as patients wrestle with pain, frustration and fear, you might find yourself handling a difficult circumstance from a customer service perspective. Practices that understand the importance of effectively managing these interactions – even in the most trying circumstances – will provide great value to patients while reaping long-term benefits.

The following tips can help you handle difficult situations in your practice:

Stay calm and listen carefully. It can be difficult to stay calm when your heart is racing and you are faced with a challenging patient, yet it is critical to remain courteous and attentive. Stop talking. Listen carefully to the patient, giving your complete attention to his or her concerns. Listen with your eyes, ears and heart. An apology can soothe a tense situation, whether you caused the issue or not. While “one size does not fit all,” a calm demeanor and careful listening go a long way.

Treat the patient as you would want to be treated. Avoid being defensive; instead,ask polite and sincere questions to help you better understand the situation. When you try to justify or over-explain, it will only sound like an excuse to the patient. A respectful tone builds bridges; a harsh tone erects walls. Consider the patient’s point of view, not just your own. Focus on the issues, not the personality. Importantly, show consideration for the patient’s age, culture and/or language, since there may be differences in perceptions based on the patient’s upbringing or belief system. Demonstrate empathy, letting patients know you understand their feelings.

Document the situation. If listening, asking questions and offering an apology such as “I am sorry that we didn’t meet your expectations” does not resolve the issue, explain that you would like to document the complaint and provide it to your supervisor. This attention often diffuses the situation and can protect you as well.

Gain a clear understanding of the facts. Don’t attempt to solve the problem before there is a clear understanding of the facts. Once you recognize the facts of the situation, tell the patient what you can do. Determine when you will call the patient back and follow through. Finally, you should conclude by asking the patient what else you can do for him or her.

If you can't solve the problem – but someone else in the practice can – record the facts and refer the situation to that individual. Ultimately, there will be times when problems cannot be resolved to the patient's satisfaction; in these instances, the physician should be notified. That (in combination with a bad outcome) can lead to a lawsuit.

Revisit the issue. After you have resolved the situation, consider the complaint again. Is there anything that your practice can do to avoid the problem in the future? Progress requires readiness to change. Reflecting on situations that gave rise to patient complaints may provide valuable insight into opportunities for future improvement.

When you are prepared for difficult situations, they will be easier to handle and lead to more positive relationships with your patients.

Practices in Multiple States Fall Victim to Ransomware Attacks

Current headlines contain many stories of cyber-attacks, including data breaches and ransom malware, more commonly known as ransomware. Once your practice is hit by a cyber-attack, you'll want to be able to quickly diminish the damages inflicted on your practice and your patients. Such damages include interruption of your practice; IT forensics to assess whether PHI was compromised; and costs for recovery of records, ransom, future monitoring and/or the subsequent patient notifications. In addition, there are potential regulatory fines and penalties. An important step to protect your practice is to secure a cybersecurity insurance policy, which will guide you through the process of recovery and help mitigate the damages.

Many cyberattacks target healthcare related companies and involve millions of patient records. The records of healthcare entities of all sizes have been held hostage by ransomware - from solo practices to hospital systems, and across multiple state lines. Here are some recent examples, some from SVMIC's own policyholders:

- The server for a medical practice in Alabama was down for five days before they realized that their system had been hacked and their records were being held for a $7,000 ransom. Fortunately, their EHR vendor encrypted all of their data, and they determined there was no risk of a data breach. They are working to restore all of their data from back-up.
- Another practice in Arkansas fell victim to a ransomware attack when they clicked a link agreeing to complete updates from what appeared to be Microsoft. Once they clicked the link, their files were encrypted and ransom was requested. They are working to restore files from back-up and conducting additional investigations to ensure that PHI was not accessed.
- What started as another ordinary day at the office at one Middle Tennessee medical practice soon turned into pandemonium when an employee received a notice of ransom malware upon logging into the computer system. A cybercriminal was holding ninety-nine percent of their patient records hostage, asking for ransom in order to release them.

Fortunately, this practice had a good back-up system in place. The records were backed up nightly which allowed for recovery of up-to-date information. The practice notified the IT firm with which they contracted, and they were able to recreate the records from back-up without paying the ransom and with minimal downtime to the practice.

- In East Tennessee, an employee of a physician's office opened an email and attachment from a presumed vendor that handled collections for the practice. However, the email was really a phishing email in disguise, and the attachment contained ransom malware. Luckily, as in the previous case, the practice had an IT vendor who was able to restore their records from back-up.

- A large practice in Arkansas received a phishing email disguised as an email from a trusted source. Once the attachment was opened, it released ransomware, which encrypted all of their patient records and prohibited the practice from accessing them. The ransom of $500 was paid to release the records.

According to Kayla Thrailkill in her article "Ransomware Attacks Increased by 167% in 2016" for Techtalk.pcpitstop.com, the number of ransomware attacks grew from 3.8 million in 2015 to 638 million in 2016. In most ransomware cases, the ransomware comes in the form of an attachment to an email. Once the attachment is opened, the ransomware encrypts or builds a firewall around the data so that the data owner cannot access it.

The HIPAA Breach Notification Rule requires HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information. In ransomware cases, the practice must "demonstrate that there is a low probability that the protected health information (PHI) has been compromised", according to the ransomware fact sheet found on the HHS website[1]. The risk assessment, according to the fact sheet, must contain at least the following four factors: "the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; the unauthorized person who used the PHI or to whom the disclosure was made; whether the PHI was actually acquired or viewed; and the extent to which the risk to the PHI has been mitigated." Due to the technical nature of a ransomware attack, it may be necessary to engage the services of a digital forensic company in order to demonstrate a low probability that PHI has been compromised.

There are steps you can take to prevent becoming a victim of a ransomware attack. Employee education is important. Cybercriminals are getting smarter and are able to disguise their phishing emails to appear to come from one of your vendors or another trusted source. Caution should be used before opening any attachment, and verification of the email source should be done for all incoming emails, especially those with an attachment.

While not all practices can afford to employ their own IT security expert, it pays to have an evaluation by a qualified firm and establish a relationship. Contracting with an IT firm that is able to deal with any cybersecurity situation in a timely manner allows for minimal down time for the office. As illustrated in the cases above, regular back-up of data is key in battling a ransomware attack. In his article titled "How to prevent ransomware: What one company learned the hard way" on PCWorld.com, Robert Lemos quoted one expert at a network-security firm who advises that online back-ups that occur automatically are best.

Even with the most prudent measures in place, you can still become a victim of a cyberattack. Although not all attacks can be prevented, a partnership with a cybersecurity insurance company can facilitate your response and mitigate the damages. Cybersecurity policies may offset the costs of recovering your data and breach notification expenses as well as some incurred fines and penalties.

SVMIC's professional liability policy includes supplemental cybersecurity coverage in the amount of $50,000. Through our partnership with NAS Insurance Services, SVMIC is pleased to be able to offer access to discounted premiums on increased limits for cyber and regulatory insurance policies to our policyholders. Please contact the Underwriting Department at SVMIC at 800.342.2239 for more information.

[1] https://www.hhs.gov/sites/default/files/RansomwareFactSheet.pdf

Risk Pearls: March 2017

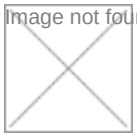
By Julie Loomis, RN, JD

One of the simplest tools for improving your communication with patients is intentional or "active" listening. When a new mother brings her baby to the office, listening to her description of the problem often provides that subtle clue a physical examination may not have revealed. Not all medical interactions require intervention; listening may be the only care needed. Keep in mind that patient experience surveys measure patients' perspectives of care by asking "How often did your doctors/nurses listen carefully to you?" Active listening sounds easy, but in today's medical environment, you may be tempted to "short cut" time allowed for listening; you may listen only for the responses that fit the questions being asked or to complete a template, thereby missing critical information. EHRs can be a barrier to active listening. By facing the patient and maintaining eye contact, you have more opportunity to “hear” the patient. Listening requires effort on the part of the practice in order to structure patient interactions that allow for open communication. Look at your questionnaires to see if they lead only to "yes" or "no" responses. If so, change the questions to make them more open-ended. Listening also requires the discipline to hear what is being said without immediately formulating a response. From the initial patient call requesting an appointment to your end of visit summary, each step in the patient experience involves listening attentively to ensure effective communication and quality care.

An Analysis of Hospitalist Closed Claims

By Carolyn Akland, MBA, RN, CPHQ, LNCC

A review of SVMIC hospitalist closed claims from 2008 – 2015, where a loss was paid on behalf of an insured, reveals three basic areas that contributed to the indefensibility of the claims. These issues are illustrated in the graph below:



COMMUNICATION ISSUES: Effective communication is essential in establishing trust and building good patient rapport, which in turn plays a role in a patient's perception of the quality of care received and helps ensure compliance. National data, as well as our data, suggests that patient handoffs between physicians continues to be a significant source of liability for hospitalists. Communication breakdowns occurred in 69% of the reviewed claims, with the majority of these claims being breakdowns between physicians. Case examples include:

In one case, an elderly patient with a non-displaced fracture was transported to an ED without orthopedic services. The hospitalist admitted the patient for pneumonia and stabilized the extremity with a short leg posterior splint including ACE wrap. After discharge, the patient was seen by an orthopedic surgeon who discovered a large pressure blister and ulceration which eventually resulted in osteomyelitis and a below the knee amputation. A lack of documentation as to the nature and extent of the neurovascular examinations of the extremity made it difficult to defend against the plaintiff's allegations that both the hospitalist and hospital nurses failed to properly evaluate the patient's neurovascular condition during the hospitalization.

In another case, a 65-year-old patient became hypotensive following a total abdominal colectomy. The patient continued to deteriorate throughout the night and the nurses notified both the hospitalist and the on call surgeon. The hospitalist remained at the bedside but the surgeon did not come in even though he was notified of the patient's status periodically throughout the night. The patient coded in early morning and was taken to surgery where an arterial bleed was found. The patient suffered an anoxic brain injury. Finger pointing ensued. The surgeon, as the principle target in the suit, said the nurses led him to believe the hospitalist had matters under control and blamed the hospitalist for not communicating with him directly.

MEDICATION ISSUES: Medication errors were present in 38% of the reviewed cases.

Medication reconciliation and prescribing at discharge continue to pose significant risk for hospitalists. The case below exemplifies this risk:

After undergoing a total knee replacement, a 46-year-old patient developed a hematoma necessitating additional surgical procedures and antibiotic therapy. The hospitalist ordered Gentamycin and discharged the patient to home health for two more weeks of home infusion therapy with the antibiotics. The orthopedic surgeon continued to refill the Gentamycin; neither physician had ordered any monitoring protocol. Two months later, the patient developed debilitating symptoms of dizziness and imbalance. A referral to the ENT determined the patient had sustained vestibular damage, most likely from the Gentamycin. The hospitalist, having been the one to order the antibiotic initially, bore the brunt of the responsibility for failing to appreciate the risks of aminoglycoside toxicity, inform the patient of those risks and to order monitoring blood tests upon discharge.

DOCUMENTATION ISSUES: Maintaining a well-documented medical record, from both a patient care and a risk management standpoint, is crucial. As the graph above illustrates, documentation issues were a factor in 38% of claims paid for hospitalists. Of those, including the cases cited above, most had inadequate documentation, which can negatively impact the ability to defend the care provided to a patient. Most often there was a failure to completely document the extent and details of an examination; rationale for the diagnosis and treatment plan; and patient education and telephone calls.

Lessons Learned:

- Communicate directly with the surgeon or other consultants treating the patient, to ensure a clear message. Do not assume that telling one nurse is as good as informing all involved in the care of the patient and don't assume vital information will get communicated through your notes alone.
- Understand the risks of accepting and admitting patients who might need the care of a specialist not on staff at your hospital.
- Educate yourself about all hospital by-laws and policies, including how to escalate up the chain of command.
- Clearly and timely, communicate/document information about patients with anticipated problems to covering hospitalists, including information regarding your treatment plans under consideration.
- Utilize a dedicated "hand-off" method between hospitalists.
- Be aware that any written or electronic "hand-off" between hospitalists is potentially discoverable.
- Document only formal consults in the progress notes.
- If your treatment plan deviates from any local community standard or nationally recognized guidelines, document your rationale for doing so.
- Verbal orders require caution. Use sparingly and employ "read-back" for verification and a time for face-to-face questioning.
- Include specific clinical parameters in your orders that instruct not only the frequency but also specifically what should be assessed and when the physician

should be notified.

- Do a thorough physical exam and history of the patient and document the findings. Avoid ambiguous notes such as “doing ok” or “CNS normal”.
- If medications or other history is not available upon admission and the patient/family are poor historians, document such along with your efforts to obtain that information.
- Understand potential risks with EHR: Use copy/paste with extreme care. Never copy information in a manner to make it appear that you provided services you did not personally provide. Read the note in its entirety to verify accuracy before signing.
- Document the phone conversations with other physicians to include name, date and time of call as well as the essence of the exchange.
- Minimize the risks at discharge:
    - Make an effort not to order unnecessary tests.
    - The discharge summary should prominently list what test results are still pending and recommended follow-up tests. Make arrangements for the discharge summary to be sent to the primary care physician in a timely manner. If the patient has no primary care physician, work with hospital professionals to arrange follow-up care and communicate the discharge summary to those providers.
    - Ensure tests ordered by yourself (or the previous hospitalist) have been returned. If these test results will not be reviewed by a hospitalist prior to discharge, it is crucial to have a system in place to review these in a timely fashion. Test results that return after discharge should be communicated directly to the primary care physician. If the results are significantly abnormal or urgent, directly call the primary care physician office and document that conversation.
    - Clearly communicate to patients and document the rationale for starting new medications, as well as significant risks, when initiating a new medication.
    - Clearly communicate to the patient the importance of keeping a follow-up appointment with the primary care physician.
    - Notify the patient of tests that are still pending and other incidental findings in need of further outpatient workup. Advise them to contact their attending physician if pending test results are not received.
    - Give the patient a copy of those instructions.
