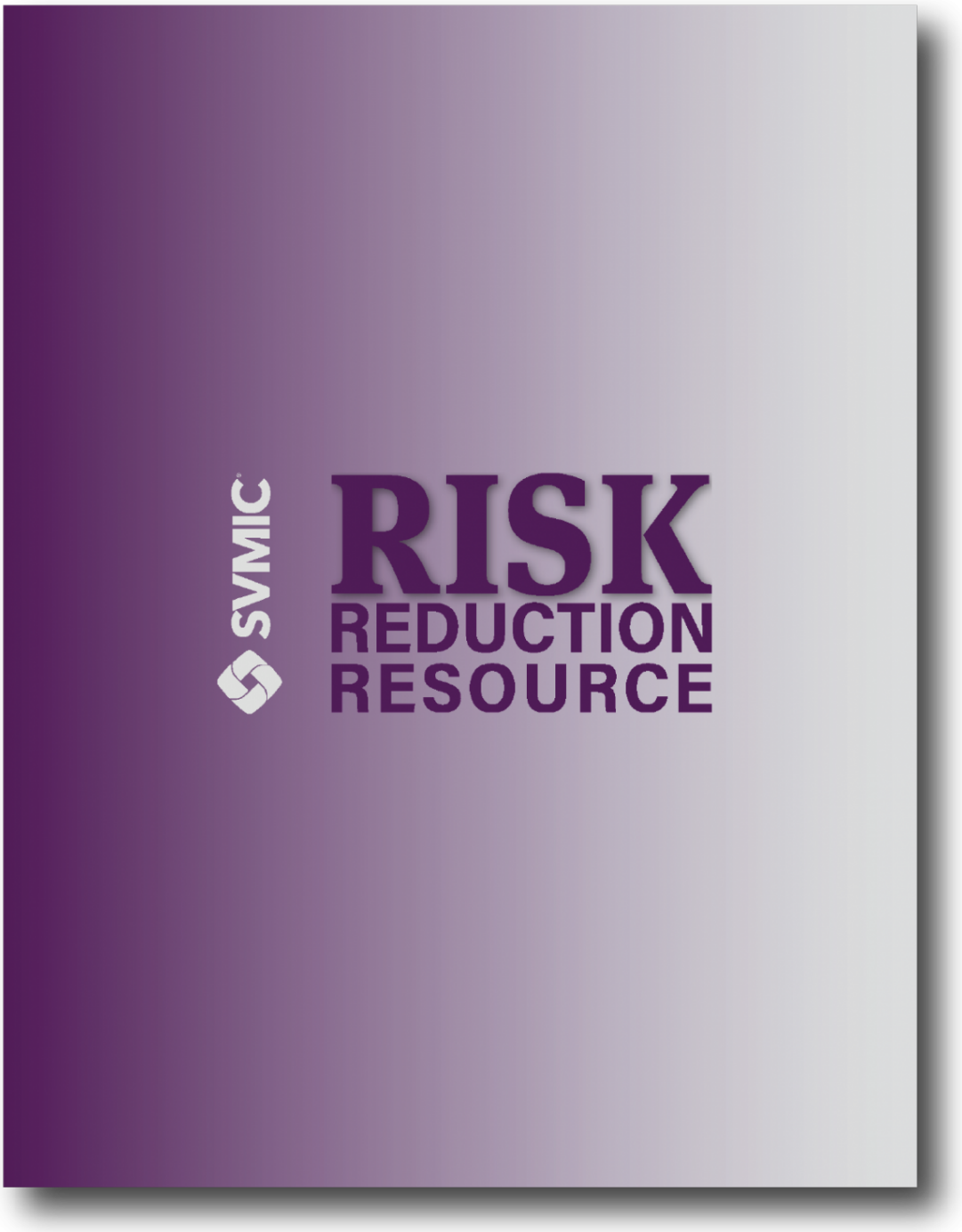
Newly Revised Risk Reduction Resource for Your Practice



By Robin Buter, BSN, RN, LNCC

Are your current office systems and processes protecting you from a lawsuit or leaving you vulnerable? Even well-established processes can break down when circumstances in your office change, such as opening an additional practice site, EHR modifications, and staff turnover. National and internal data suggest that non-clinical factors often contribute to malpractice lawsuits; therefore, risk mitigation strategies involving your office environment and staff are critically important.

Chances are you could use a resource to guide you and your staff in basic strategies for risk management. The SVMIC Risk Education and Evaluation Services (REES) Department is pleased to share with our policyholders and their practices our newly revised **Risk Reduction Resource** (formerly Risk Reduction Guide).

The Risk Reduction Resource was designed to assist SVMIC policyholders and staff with strategies to improve patient safety and reduce liability exposure in the medical practice setting. The Resource includes fundamental risk management concepts such as provider-patient relations, office systems and processes, medical record documentation, medication and office safety, and emergency procedures. Common questions are addressed such as "How much follow-up is necessary in the event of a missed appointment?" or "What is my responsibility if I receive unsolicited test results?"

This Resource is intended to provide general risk mitigation guidance. Policyholders are encouraged to consult an SVMIC Claims Attorney, a Risk Education Attorney or Specialist, or a Risk Evaluation Consultant with specific questions or concerns.

Members and their staff can access the Risk Reduction Resource here. We encourage you to bookmark it in your Vantage® portal!

Public Health Emergency Extended Once Again – but End is Near

By Elizabeth Woodcock, MBA, FACMPE, CPC

Despite declaring the pandemic was “over,” the federal government extended the public health emergency (PHE) for another 90 days last month. The PHE, which now expires on January 11, 2023, has been in place since early 2020. Now in its third year, it’s difficult to remember what flexibilities it affords. As experts predict this may be the final renewal, it’s an opportune time to review the relevant waivers that will expire with the emergency declaration.

When the PHE concludes, the following changes may be made by the Centers for Medicare & Medicaid Services (CMS) for Medicare beneficiaries:

- Health care professionals – physical therapists, speech language pathologists, etc. – who are not physicians or advanced practice providers will no longer be able to provide services via telemedicine.
- Audio-only services will be corralled, instead requiring audio and video equipment

that permits a two-way, real-time interaction between the patient and the provider unless an exception is granted for the particular service.
- Provider enrollment will roll back to pre-pandemic procedures; there will be no expedited processing. Practitioners will be required to resume reporting their home address on the Medicare enrollment. States will again oversee where a provider can practice.
- Patients outside of rural areas and patients in their homes will no longer be eligible for telemedicine services. Prior to the pandemic, Medicare covered telemedicine when it was in a physician office or hospital setting, and it is expected that this will again be the case.

These changes will be set in stone 151 days after the conclusion of the PHE, allowing several months to transition back to the pre-pandemic protocols.

The government is accepting applications to waive these impending changes if dictated by your situation (or that of your patient[s]). Send your request or questions to 1135waiver@cms.hhs.gov. If you are serving a home-bound patient via telemedicine, for example, consider applying for an exemption.

For more information about the conclusion of the PHE, see this link.

Risk Matters: 2022 Risk Wrap Up

By Jeffrey A. Woods, JD

Most loyal readers of the Sentinel are familiar with the Risk Education department because of the monthly “Risk Matters” column. You may also know the department as the arm of your company that produces live seminars and develops many of our online courses. However, some of you may not be aware that we are SVMIC’s version of a risk management department. We answer policyholder questions related to risk/potential liability as well as other legal issues that arise in the practice setting. Many of the topics of the Risk Matters articles are taken from questions we received from physicians, advanced practice practitioners, and practice executives. We believe that if one policyholder has a question about a particular subject, so do others. In case you missed one, here is a list of this year’s topics:

COVID-19 Vaccines

New Course on Litigation

Physician Health & Well-being

Sample Medication Management

Tracking Referrals & Consultations

Chaperones

Tracking Procedures

Avoid Using Disclaimers for Dictation, Voice Recognition Software, Electronic Health Records

Supervision and Delegation of Advanced Practice Practitioners

Requirements for Patient Accessing & Posting Results

If you have a question you would like to discuss with one of the attorneys in the Risk Education department, you can contact us by phone at (800) 342-2239 and asking to speak to a Risk Education attorney, by email at ContactSVMIC@svmic.com, or through the Vantage® portal. Of course, you can also talk to one of our Claims Attorneys in the Claims Department. The abundance of legal resources available to our policyholders is one of the key factors that distinguishes SVMIC from other professional liability carriers.

Medication Management Mistakes

By Stephanie Walkley, JD, BSN

Linda Powell[1], a 52-year-old woman, presented to the office of gynecologist Dr. Brenda Farmer for an annual exam in June. During the office visit, Ms. Powell complained of bloating and fluid retention associated with her menstrual cycle. For these complaints, Dr. Farmer prescribed Dyazide™, writing the prescription for one pill by mouth once a day with 30 pills; the prescription included six refills.

According to Dr. Farmer, she counseled the patient to use the Dyazide only as needed during her menstrual cycle. However, Dr. Farmer failed to record her instructions to the patient in the visit note or elsewhere in the medical record, and the label on the prescription did not reflect this instruction.

Approximately two weeks after receiving and filling the original prescription, Ms. Powell called Dr. Farmer's office, informing the nurse that the Dyazide had worked well for two weeks but requesting an increase in the dosage. Without consulting Dr. Farmer, the nurse "increased the Dyazide to 2 every other day."

One month after receiving the new dosing instruction from Dr. Farmer's nurse, Ms. Powell

called the office and stated that her Dyazide prescription had been doubled and that she had run out of refills. Ms. Powell requested more Dyazide. Without any investigation regarding Ms. Powell's statement that she had run out of refills, Dr. Farmer authorized another prescription for Dyazide with instructions of one pill by mouth once a day with 30 pills and six refills.

Ms. Powell had the medication refilled three times before returning in October for an office visit. During the visit, Ms. Powell indicated that the Dyazide was not working well for her. Dr. Farmer told the patient to stop taking the Dyazide and prescribed spironolactone instead. Despite these verbal instructions, there is nothing in the medical record documenting that Dr. Farmer instructed Ms. Powell to stop the Dyazide. The record only reflects that spironolactone had been prescribed.

Pharmacy records indicate that Ms. Powell filled the spironolactone once following the October visit but never again. She began taking the Dyazide again in November without consulting Dr. Farmer. Over the next eight months, Ms. Powell refilled the Dyazide six times.[2]

In July, over one year after the initial prescription, Ms. Powell called Dr. Farmer's office for another refill of Dyazide. A new nurse, without realizing Dr. Farmer had discontinued it, and without questioning the patient or consulting Dr. Farmer, called in a one-month supply.

Two weeks later Ms. Powell collapsed at home, and a family member called 911. Shortly before the EMTs arrived, Ms. Powell went into cardiac arrest. Upon arrival, the EMTs initiated resuscitation measures and transported Ms. Powell to the emergency room. After arriving at the hospital, the medical team succeeded with resuscitation.

Tragically, Ms. Powell suffered an anoxic brain injury. Initial lab work at the hospital revealed a potassium level of 2.1. After several days in the ICU, Ms. Powell was transferred to hospice care where she remained until her death a few days later. Ms. Powell's death certificate listed her cause of death as anoxic brain injury resulting from ventricular arrhythmia.

Less than one year after her death, Ms. Powell's family filed a wrongful death suit against Dr. Farmer and her practice. The complaint alleged that Dr. Farmer failed to meet the standard of care for managing and monitoring chronic diuretic therapy. More specifically, it alleged that failure to monitor Ms. Powell's potassium levels resulted in hypokalemia which led to cardiac arrhythmia and, ultimately, death.

The chasm between the medical records and the testimony of Dr. Farmer made a successful defense of this case very difficult. In her deposition, Dr. Farmer testified that she does not prescribe or oversee chronic diuretic therapy but only prescribes diuretics on an as-needed basis which does not require potassium monitoring. If a patient needs daily diuretics, then the patient is referred to their primary care physician for management. This was Dr. Farmer's testimony even though within the first two months of seeing Ms. Powell, she authorized prescriptions for fourteen months of daily Dyazide.

Similarly, Dr. Farmer testified in her deposition that she instructed Ms. Powell at the initial June visit to take the Dyazide only as needed; however, the medical records did not support her testimony. In fact, her testimony conflicted with the actual instructions written for the prescription which read to take one pill daily. The discrepancy between her testimony and the medical records presented not only a standard of care challenge, but also a credibility issue.

In some cases, it is possible to prevail even when the standard of care is not met if the alleged negligence did not cause an injury to the patient. This was not one of those cases. Although the likelihood of hypokalemia from Dyazide is low, it is possible, and it provided a straightforward explanation for Ms. Powell's arrhythmia and subsequent death. Dr. Farmer admitted in her deposition that chronic diuretic therapy requires electrolyte monitoring, which was not done in this case. Furthermore, the defense experts conceded that Dyazide could have caused hypokalemia, arrhythmia, and death.

The defense experts could not provide an alternative explanation for the cause of Ms. Powell's cardiac arrest. Given the issues with the overall defensibility of the case, the parties settled several months prior to the scheduled trial date.

Unfortunately, Dr. Farmer and her staff missed numerous opportunities to recognize a problem with the patient's medication management. Some recommendations that can be drawn from this case:

1. develop and maintain a policy for prescribing and dispensing all medications that includes a clear direction that staff should not renew prescriptions without specific provider approval;
2. document important conversations with the patient regarding medication management;
3. make sure that verbal and written instructions are consistent;
4. review patients' prescription history carefully before authorizing refills;
5. question unusual refill requests; and
6. order appropriate tests for monitoring if needed.

For more information, please click here.

[1] Names have been changed.

[2] During the discovery process, the defense team learned that Ms. Powell had gone to her PCP in November for the same complaint of edema. Her PCP provided her with yet another prescription for Dyazide. The lawsuit did not name the PCP as a defendant.
