Time Well Spent

By Stephanie Deupree, JD, BSN

Kelly Johnson, a 45-year-old G0P0[1], presented to the office of gynecologist Dr. Belinda Smith after being referred for evaluation of chronic pelvic pain.[2] Mrs. Johnson had an extensive history of gynecological problems including endometriosis and ovarian cysts. Prior to her appointment with Dr. Smith, Mrs. Johnson had seen multiple gynecologists over the last several years and had numerous operations. In addition to her gynecological and chronic pain issues, Mrs. Johnson suffered from an anxiety disorder. Her daily medication regimen included Xanax and Lortab.

During the appointment, Dr. Smith examined Mrs. Johnson and reviewed her medical records from other providers. Mrs. Johnson expressed the desire to be free of pelvic pain. Following the exam and record review, Dr. Smith discussed various surgical options. Mrs. Johnson did not make any decisions regarding treatment that day.

A few weeks later Mrs. Johnson returned to see Dr. Smith. At this visit, Mrs. Johnson wanted to go over her surgical options again. Dr. Smith recommended laparoscopic right salpingo-oophorectomy. After some discussion, Mrs. Johnson agreed to proceed with the

surgery and signed a consent form that listed the procedure as “laparoscopy of right tube and ovary with lysis of adhesions.”

Three weeks later, on the morning of the scheduled afternoon surgery, Mrs. Johnson and her husband called Dr. Smith’s office and spoke with her nurse. The Johnsons advised the nurse that after some thought and deliberation Mrs. Johnson wanted to have a hysterectomy. They asked the nurse to get a message to Dr. Smith as soon as possible. The nurse was able to contact Dr. Smith and relay this new information and request.

Upon arrival to the hospital, Mrs. Johnson, who did not take her usual morning Xanax, began experiencing panic attacks. She was upset because she thought she would be given something soon after arriving. She asked for medication to help her with the panic attacks and was given Versed.

A couple of hours later, Dr. Smith saw Mr. and Mrs. Johnson together in the preoperative holding area. They both inquired about whether she had received their message about wanting to proceed with the more extensive surgery. Concerned with whether the patient had been given any medication since her arrival that could influence her ability to consent, Dr. Smith asked the nursing staff if Mrs. Johnson had received any medication. The nurse assigned to Mrs. Johnson informed Dr. Smith that Mrs. Johnson had not received anything that would affect her ability to consent. Unbeknownst to Dr. Smith, the medical record would later reveal that Mrs. Johnson had received Versed prior to their meeting in preoperative holding. Mrs. Johnson appeared completely lucid and conversed appropriately.

Dr. Smith discussed hysterectomy in depth with the Johnsons. After providing a full explanation of the risks and benefits of the procedure, Dr. Smith took the previously signed consent form and added “removal of uterus and left ovary.” She had both Mr. and Mrs. Johnson and the nurse initial this addendum to the consent. Dr. Smith did not write a progress note to memorialize her discussion with the Johnsons regarding their requested change in surgery and the detailed informed consent discussion that followed.

Dr. Smith proceeded with performing the hysterectomy as well as removing both fallopian tubes and ovaries. The surgery went well without any problems or complications. Mrs. Johnson stayed in the hospital overnight and was discharged home the following day.

When Mrs. Johnson returned for her first postoperative office visit 10 days later, she never mentioned any shock or dismay about the hysterectomy. Many weeks later, during her final postoperative visit, Mrs. Johnson remarked for the first and only time about the hysterectomy. After being denied a refill for a pain medication, Mrs. Johnson expressed anger over having the hysterectomy because it had not resolved her pain. Dr. Smith did not hear from Mrs. Johnson again.

The next time Dr. Smith saw Mrs. Johnson’s name was in a lawsuit complaint, which alleged medical malpractice, medical battery, and lack of informed consent. Mrs. Johnson averred that she was shocked to learn that she had had a hysterectomy after waking up in

the recovery room. Similarly, Mr. Johnson purportedly learned of the hysterectomy from his wife days later. The crux of the lawsuit was that Mrs. Johnson was heavily medicated and could not consent to the change in procedure. Furthermore, the Johnsons claimed that the surgery deprived Mrs. Johnson of the opportunity to harvest her eggs for future IVF so that either she or a surrogate could carry a pregnancy to term.

The filing of the complaint began multiyear litigation that culminated in a 7-day jury trial. The Johnsons did not make particularly favorable witnesses. Nonetheless, their attorney put on proof through medical experts in support of their allegations. Fortunately, Dr. Smith did an exceptional job during her testimony. Defense counsel presented gynecology and pharmacology experts at trial—the gynecology expert supported Dr. Smith on the standard of care while the pharmacology expert was able to show that the timing and dosage of the Versed for this particular patient should not have negatively impacted her at the time she consented to the hysterectomy. Ultimately, the jury found in favor of Dr. Smith and returned a defense verdict.

There were several things in the evidence that inured to Dr. Smith's benefit. First, the nurse in Dr. Smith's office documented her conversation with the Johnsons on the morning of surgery very well. Second, in this unusual circumstance, having the patient, the patient's husband, and the nurse initial the addendum to the consent bolstered the defense of the case.[3] In the absence of a progress note from Dr. Smith regarding an informed consent discussion about hysterectomy, these pieces of documentation became especially important in the defense of the medical battery and lack of informed consent claims. Third, the medical records of other providers helped cast doubt on the allegations the Johnsons made about their desire to start a family through assisted reproductive technology. The importance of adequate documentation cannot be overstated.

Although Dr. Smith prevailed after several years of litigation, this entire case may have been avoided if some relatively simple measures had been taken. Perhaps the easiest and most obvious issue that could have been avoided was having the patient sign her consent after the administration of Versed. Even though Dr. Smith should have been able to rely upon the hospital nurse to give her accurate information about any medications that had been administered, the more prudent course would have been to verify exactly what medications had been given and when. If Dr. Smith had learned that Mrs. Johnson had received Versed one would hope that she would not have proceeded with the change in procedure or have the patient sign anything. As a general rule, patients should not have informed consent discussions with their providers or sign any documents, particularly consent forms, after they have received any medication that could potentially impact their capacity for decision-making.

Further, the surgery, although medically indicated, was done on a purely elective basis. It was not a medical emergency and time was not of the essence. On occasion there may be circumstances that warrant changing the planned procedure on the scheduled surgery day. When choosing to forge ahead, it is imperative to take the time to have an informed consent discussion just as you would in office. Likewise, take the time to write or dictate a

note prior to the procedure. Time stamps for notes concerning informed consent made after the procedure can appear self-serving, especially if problems arise during the procedure. The physician should use his or her medical judgment to decide if changing the procedure necessitates rescheduling. This must be determined on a case-by-case basis.

In closing, remember that thorough documentation is often the best defense! Take the time to document the medical record appropriately and thoroughly. The time it takes to write or dictate a progress note is far less than the time it takes to defend a lawsuit.

[1] G0P0 refers to a gravida 0 para 0 patient – a female who has never been pregnant and never delivered a child.

[2] The names of the patient and physician have been changed.

[3] Although having a spouse's consent is unnecessary and would seem to be a throwback to a more draconian era, in this very limited case it proved helpful during litigation. Neither Ms. Deupree nor SVMIC recommend or suggest that any female patient requires the consent of a spouse for any medical procedure. Noting the particular facts of this case does not constitute an endorsement or recommendation of having health care providers obtain consent from a patient's spouse in a non-emergent situation. In most cases, a competent patient in a non-emergent situation is the only one that may give consent.

Missed Appointments in the Time of COVID-19

By Jeffrey A. Woods, JD

From a financial standpoint, missed appointments and “no-shows” have always been a significant problem for healthcare practitioners. It has been estimated that, prior to the COVID-19 pandemic of 2020, the cost of missed patient appointments was more than $150 billion annually. Of course, the “cost” goes far beyond the financial aspects. Missed appointments are often related to critical follow-up for chronic disease management or preventive screenings. If these patients later experience an illness, injury or loss, they may hold the healthcare provider responsible and assert a malpractice claim.

According to some surveys, prior to March 2020, patient no-show rates ranged anywhere from 5% to 50% depending on the type of healthcare practice and location. Since the onset of COVID-19, SVMIC policyholders have reported that the number of missed appointments and no-shows have escalated and therefore increased the risks to patient safety.

The primary causes identified for missed appointments and no-shows are the same now as they were prior to the pandemic, but they have been significantly exacerbated. To reduce the number of missed appointments and no-shows, it is important to first examine the primary causes to understand how and why they occur.

COST: Higher deductibles and out-of-pocket costs combined with confusion about preventive care coverage means that some missed patient appointments are simply in response to financial strain. As we all know from the continuous stories in the news, the pandemic has increased that financial strain by causing large-scale unemployment, loss of insurance, and a shift in priorities.

FEAR: Many people generally dread going to the doctor under normal circumstances. They are afraid of bad news or that the doctor will lecture them about unhealthy behaviors or not following medical advice. They also dislike spending time in a waiting area exposed to other patients, increasing their risk of contracting something. Again, the risk of exposure to COVID-19 has only increased these fears.

TIME: Work and family commitments often take precedence over personal health particularly with regards to regular office visits and preventive care. The pandemic has created additional childcare issues and home-schooling requirements for many parents.

DEMOGRAPHICS: Disadvantaged populations often have more difficulty keeping appointments due to income, language, or age barriers. Patients who are elderly may no longer drive, and patients who have lost their jobs may not have reliable transportation. Despite their circumstances, they may be reluctant to use public transportation particularly in the current environment. Patients in rural areas may not even have access to public transportation. The challenges presented by these and other demographic conditions may have become more pronounced because of the COVID-19 crisis.

WHAT CAN BE DONE?

First, let's look at the factors identified above. With respect to cost, providers are encouraged to work with patients who have a financial hardship caused or affected by the pandemic. Everyone understands that a medical practice is a business, and these businesses have suffered too during the pandemic. But, to the extent possible, helping patients during this difficult time by making alternative pay arrangements, such as payment plans, will hopefully increase patient safety, decrease potential claims, and establish a long-term physician-patient relationships that will extend beyond the COVID-19 pandemic.

Alleviating a patient's fear can be done in a multitude of ways, but it typically starts through better communication and education. Many practices are using targeted emails, website information, and patient portals to notify their existing and prospective patients of the steps

the practice is taking to ensure patient safety and reduce the risk of COVID-19 transmission during in-person visits. These steps often include contactless registration and having patients wait in their car until they can be placed in an examination room. Practices are also adopting telehealth to provide patients with an alternative to in-person visits.

Some practices have addressed the time problem by implementing protocols allowing only one patient to be scheduled in the office per time slot. Again, telehealth is an alternative that would allow patients to keep their appointments, especially routine and follow-up visits, while also maintaining their family and work obligations.

Demographics may be the most difficult obstacle for a practice to overcome. But, again, through communication and education as well as telehealth, some of these obstacles can be overcome.

Regardless of the reasons or the circumstances (pandemic or no pandemic), when medical practices are challenged with missed appointments during which follow-up care or treatment was to be provided, it is important that the practice have a procedure to ensure that no-shows and cancellations are communicated to the treating provider, and any actions taken are documented in the medical record.

Depending on the patient's diagnosis and/or reason for the appointment, the treating provider may instruct an assigned staff member to follow-up missed appointments either verbally or by way of a "missed appointment letter." Generally, the efforts required to contact the patient are commensurate with the severity of the patient's medical condition and potential consequences of missed treatment.

When notifying the treating provider of a missed appointment, staff should include the reason for the visit. Depending on the patient's diagnosis and/or reason for the appointment, the treating provider may instruct that the patient be contacted and informed of the need for the appointment to be rescheduled and kept. Instructions should include the time frame (e.g., "call patient to reschedule, should be seen within 7-10 days").

If a patient is at minimal risk (e.g. a well checkup), no action may be required or a single phone call or letter outlining the consequences of failure to receive needed treatment in a timely manner may be sufficient.

For patients at moderate risk, such as those who need ongoing monitoring or treatment, a more concerted effort may be required. Usually two documented phone calls and a *certified* letter outlining the consequences of failure to receive needed treatment in a timely manner should be adequate.

If the missed appointment is for the purpose of notifying the patient of abnormal test results requiring further treatment, failure to follow-up on a missed appointment could lead to a delay in diagnosis if the patient is not notified and treatment does not ensue. Generally, the reasonableness of the follow-up effort will depend on the clinical importance of the test results, the severity of the patient's medical condition, and the risk

associated with failing to notify the patient of the results.

All efforts to educate the patient and complete the follow-up should always be documented in the medical record. If letters are sent, they should be in clear, reader-friendly language at a fourth-grade reading level in order to be understandable and in compliance with Limited-English Proficiency Guidelines. If the letter is returned undeliverable, verify that the address on the letter corresponds with the address given by the patient, and if a new address is provided by the post office, resend the letter to the new address and note this in the medical record. If a letter is returned because delivery was refused by the patient, resend the letter to the same address using first class regular mail.

As with all patient communication, staff should document the date and time of the call or place a copy of the missed appointment letter in the patient's medical record.

If a patient repeatedly does not return to the office after appropriate contact attempts have been made and documented, the treating provider may, as a last resort, take steps to discharge the patient from the medical practice. HOWEVER, during the COVID-19 crisis, it is strongly recommended that you consult an SVMIC Claims Attorney to discuss the circumstances prior to discharging the patient. Call 800-342-2239 or email us at ContactSVMIC@svmic.com for assistance.

Contactless Registration Tips

By Elizabeth Woodcock, MBA, FACMPE, CPC

Many practices have moved to a contactless registration process. As the term infers, the process is completed without physical interaction with the patient. Patients are seeking safe environments, and the touch-free process can offer significant benefits for your practice. Consider these strategies to achieve an efficient and effective contactless registration process:

1. “Walk through” the process from the patient’s perspective, not just from the viewpoint of your practice. Begin with the patient contemplating a contact with your practice. What do they see when they land on your website; can they seamlessly get an appointment?
2. Consider the process after the appointment is scheduled. Are the registration link and instructions clearly displayed and usable once an appointment is brokered? Does the patient get a link to your forms and questionnaires -- or do you have to tell the patient where to go? If you do, how effectively does your staff accomplish this? Are the forms and questionnaires easy to complete and free of redundancy? Your process can be terrific, but it will not work if patients cannot get there -- or get

through it.

3. Provide clear instructions to your staff. If your team does not understand the process, they won't be able to convey the inner workings to your patients. Invest time in walking them through the process by having each team member schedule an appointment for themselves. Role-playing is the best teacher! Provide scripting for your team based on frequently asked questions.
4. Segment the process for effective quality improvement. Having someone declare: "It doesn't work!" cannot and will not help you. When you provide training tools to your team, delineate each aspect of the process. Pinpoint errors connected to that segment; ask for screen shots so you can immediately get to the bottom of a problem – and fix it.
5. Supplement the process with curbside check-in. Provide a method – text a number; scan a QR code; etc. – for patients to declare their presence, thereby making both the registration and the arrival process "hands-free."
6. Provide bi-directional communication for patients. As you consider how to refine your process, do not forget about the psychology of waiting. Patients want to be informed; information transparency is critical so be sure to have mechanisms not only to pull information from patients – but to respond back as well.
7. Integrate payment mechanisms now. Getting your telemedicine program up and running was the priority, but it's now time to step back and make sure that all your arrival processes are replicated in your new workflow. That includes payment. Make sure your contactless registration process includes the ability to collect payments due at the time of service – and ideally, past balances as well.

Embrace feedback about your new process, as it's unlikely that we'll ever return to the "old" way. Watch for emails or other communication from patients about the process; embed feedback mechanisms into the process. Proactively seek advice from patients who have gone through the process by reaching out to a patient or two every few days. The road to a new workflow is riddled with potholes, but it's unlikely that we'll be making U-turns.

Adopting and perfecting contactless registration requires change, but it can elevate your practice's efficiency – and the service you provide to your patients.

A New Vantage® Feature: Vantage Discussions

By Meghan Clark

There’s no question that 2020 has forced many of us to forego our usual routines and adopt innovative, new ways of doing things – both personally and professionally. One change that many are struggling to get accustomed to is the absence of live events and the opportunity to interact face-to-face with one’s peers and colleagues. Specifically, in the professional setting the cancellation of conferences and meetings has largely eliminated opportunities to engage with peers and learn from one another. To help you stay connected during this difficult time, SVMIC is excited to introduce you to our newest Vantage ® feature: Vantage Discussions, a virtual discussion board.

Practice managers find value in meeting, sharing, and brainstorming with each other. In many cases, practices face similar challenges and, in non-competitive situations, are happy to leverage the experience of others. Vantage Discussions was developed with the practice administrator in mind, meant to help you connect and learn from one another on issues you and your practice commonly face. When you have questions, wonder what

others are doing with contactless check-in, want some insight on the Paycheck Protection Program, need some ideas on how to keep employees educated and trained, or you simply want to brainstorm better ways to organize your administrative processes, this discussion platform can be your first stop to reach out to peers across SVMIC's region to find help. Consider Vantage Discussions your virtual support group or your practice manager help forum – somewhere you can go to ask questions and find answers.

Set up as a typical discussion forum, Vantage Discussions is organized into three categories: Clinical, Administrative, and Education. Using those three categories, members can ask questions, respond to questions, and read through existing discussions. Utilizing the search feature, members can also use keywords to quickly filter through previously started discussions to easily find relevant conversations. A notification will be sent via email to members when someone responds directly to a discussion they have started, with the goal of keeping responses timely and conversations active.

The only requirement to enjoy this virtual discussion board is a Vantage account. Upon logging in, practice administrators will see the Discussions tab and can begin sharing, reading, and discussing with peers; some conversations are already ongoing so it will be easy to join in! Although the platform is not intended for communication directly with SVMIC, we hope that you can utilize Vantage Discussions to connect with your peers on a variety of topics. To connect, click here and login with your Vantage account credentials, or create your Vantage account by following the instructions. SVMIC thanks you for your participation and is excited to share this new and innovative tool with you!
