Infection Control: Shore Up Your Practice's Plan

By Julie Loomis, RN, JD

It's back to school time which means cold and flu season isn't too far away. Although a medical practice's infection control plan consists of much more than preparing for cold and flu, now might be a good time to shore up your practice's plan. According to the Centers for Disease Control and Prevention (CDC), the transition of healthcare delivery from acute care hospitals to ambulatory care settings, along with ongoing outbreaks and patient notification events, have demonstrated the need for greater understanding and implementation of basic infection prevention guidance. Americans have frequent encounters with outpatient settings. For example, CDC notes that more than three-quarters of all operations in the United States are performed in settings outside the hospital. Vulnerable patient populations rely on frequent and intensive use of outpatient care to maintain or improve their health. It is critical that all of this care be provided under conditions that minimize or eliminate risks of healthcare-associated infections (HAI).

The CDC provides examples of recent outbreaks and patient notification events. These events occurred in a variety of outpatient settings including primary care clinics, pediatric offices, cosmetic surgery centers, pain remediation clinics, imaging facilities, cancer (oncology) clinics, dental clinics, and health fairs. The list serves as a reminder of the serious consequences that can result when healthcare personnel fail to follow basic principles of infection control. Such consequences include: infection transmission to patients, notification of thousands of patients of possible exposure to bloodborne pathogens, referral of providers to licensing boards for disciplinary action, and malpractice suits filed by patients. Some of the most common examples are related to reuse of syringes to access medication vials for more than one individual patient. CDC defines this as "Double Dipping"- a syringe that has been used to inject medication into a patient then reused to enter a medication vial. The syringe is discarded but contents from that vial, which were contaminated through reuse of the used syringe, are then used for subsequent patients, which can lead to transmission of infectious agents. Other frequently noted preventable examples include failure to wear personal protective equipment (PPE), visibly dirty equipment, lack of equipment cleaning or performance checks, failure to follow aseptic technique, and mishandling of medication preparation.

Infection Control Basics

According to the CDC, there are two tiers of recommended precautions to prevent the spread of infections in healthcare settings: Standard Precautions and Transmission-Based Precautions

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Standard precautions are used for all patient care. They are based on the risk assessment and make use of common sense practices and personal protective equipment use that protect healthcare providers from infection, prevent the spread of infection from patient to patient, and prevent the spread from an infected area of a patient to a non-infected area of the same patient. *Transmission-based precautions* are used in addition to standard precautions for patients with known or suspected infections. These transmission precautions include contact precautions, droplet precautions and airborne precautions. These precautions involve understanding the viability of infectious agents and the distances they can travel.

To assist healthcare providers with an infection control plan, in September 2016 the CDC updated and published both a checklist and a complete guide to infection prevention for outpatient settings. “The Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care” is a summary guide of infection prevention recommendations for outpatient (ambulatory care) settings. The recommendations are not new but rather reflect existing evidence-based guidelines produced by the CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). The guide distills existing infection prevention guidance from the CDC and HICPAC, which is based primarily upon elements of Standard Precautions, and represents the minimum infection prevention expectations for safe care in outpatient settings.

By highlighting existing CDC and HICPAC recommendations, the guide has the following objectives: 1) provide basic infection prevention recommendations for outpatient (ambulatory care) settings; 2) reaffirm Standard Precautions as the foundation for preventing transmission of infectious agents during patient care in all healthcare settings; and 3) provide links to full guidelines and source documents, which readers can reference for more detailed background and recommendations. The guide is accompanied by an Infection Prevention for Outpatient Settings Checklist, a tool to help outpatient facilities assess their policies and procedures. In order to prevent patient harm, facilities and healthcare staff members are encouraged to review practices to assure they are in accordance with CDC’s evidence-based guidelines.

The checklist should be used for two purposes:

1. To ensure that the facility has appropriate infection prevention policies and procedures in place and supplies to allow healthcare personnel to provide safe care, and
2. To systematically assess infection prevention practices of individual healthcare personnel.

Healthcare providers are encouraged to download the CDC guide and checklist and to consult the full guidelines (in the Guidelines Library) for additional background, rationale, and evidence behind each recommendation. The Guidelines Library is categorized as follows:

- Basic Infection Prevention and Control
- Antibiotic Resistance
- Device-associated
- Procedure-associated
- Disease/Organism-specific
- Healthcare Worker Guidelines
- Setting-specific Guidelines

These are excellent tools designed to help healthcare providers implement Standard- and Transmission-Based Precautions to prevent infections in the ambulatory and outpatient settings.

Remember, it's important to protect the healthcare workers in your practice as well. The CDC has recommendations for immunizations, personal protective equipment (PPE), sharps safety and post exposure prophylaxis.

CDC publishes yearly reports to help each state better understand their progress and target areas that need assistance. These include interactive data maps for antibiotic-resistant healthcare associated infections, outpatient antibiotic prescription data and inpatient antibiotic stewardship data. CDC State-based HAI prevention success stories, data, reports and state specific resources are available here.

For additional tools, training and education resources, visit the CDC's comprehensive Infection Control website.

Perception Can Be Everything

By Zynthia T. Howse, JD

"It takes a lifetime to build a good reputation, but you can lose it in a minute." - Will Rogers

In general, physicians are widely respected. They are perceived as "healers" with good intentions. Physicians are members of society with remarkable abilities to help others. Statistics show that the general public regards physicians as the most trusted profession. Professionalism is a core competency for physicians. The journalist Alistair Cooke once stated that, "A professional is someone who can do his [her] best work when he [she] doesn't feel like it." Physicians have taken a vow under the Hippocratic Oath to give and do their best at all times.

Fortunately, this is why jurors usually believe and support physicians in a health care liability case. They want to believe that an individual who has dedicated his or her life to helping others has not caused intentional harm. People want to trust physicians. Physicians are expected to care and show compassion. Conversely, if and when a juror's perception is changed, there may be no turning back.

This case involved a 58-year old-female[1] who was admitted to the ICU due to shortness of breath, which required intubation. She was diagnosed with congestive heart failure, pneumonia, renal insufficiency, infection, and respiratory failure. Pulmonary medicine, cardiology, infectious disease, and nephrology were all consulted. The patient's condition began to deteriorate and her oxygen saturation level went down. It was believed that there might be a cuff leak. Neither the pulmonologist nor the respiratory therapist were readily available. The emergency room (ER) physician was contacted by the ICU nurse for assistance. The ER physician initially responded, "This is not my job." The pulmonologist was not on the premises but was able to persuade the ER physician to answer the call from ICU. The patient was then re-intubated and reported to be stable, but coded soon after. The patient was intubated again, but died within the hour.

The case proceeded to trial after unsuccessful negotiations to settle. As a constant in healthcare liability defense, the focus was on the medicine and expert support. There was strong expert support that the cause of death was unrelated to the endotracheal tube. In fact, defense experts opined that the patient was dying even before the ER physician became involved. This opinion was supported by the autopsy report, which identified the cause of death as pulmonary edema and heart failure.

However, one of the most important factors in any medical malpractice case is the defendant physician and how he/she is perceived and received by the jury. In the case at hand, an ICU nurse contacted the ER physician and asked for assistance. Ultimately, the

ER physician did eventually respond. The trial proof, supported by experts, demonstrated that there was no damage caused by any delay in the intubation of the patient and proved that the endotracheal tube was in the proper position. The ER physician in his clinical judgment, knowing this was not a “code” or emergent event and knowing the hospital policy for when an ER physician is to respond to the ICU, did not believe he should have been a “first responder” to the call. However, his initial response of “That is not my job” created a tense interaction between him and the ICU nurse, which was evident through the documentation in the medical record and in the nurse’s deposition and trial testimony.

Not surprisingly, some of the jurors were unable to put the ER physician’s comment aside, and several jurors were against the physician from the outset. When polled, some jurors adopted the defense case theory to the effect that the endotracheal tube was not the cause of death but were still not supportive of the physician. Others did not even consider the position of the endotracheal tube – they were hostile toward the ER physician primarily due to his comment. The statement painted the ER physician in a very unflattering light and the jurors believed that anyone who would make this statement lacked compassion and the ability to practice medicine, which is the antithesis of the Hippocratic Oath. They perceived the ER physician in a manner that did not represent the true or expected qualities of a physician. Despite the “defensible medicine” and expert proof, the unfortunate statement, “That is not my job” became a hurdle (negative perception) that the defense could not overcome. This case was settled during trial.

A physician must build trust with patients and with his/her healthcare team, and must remember that the patient is the “purpose” of their work and not an interruption. Trust is the foundation of any relationship and certainly the core foundation of service in healthcare. Trust promotes healthy interactions and cooperation among healthcare providers, which fosters efficient and effective healthcare and improves the patient’s experience. Trust builds a team, and a strong team is essential to success. It can reduce inter-professional conflict between nurses, physicians and other healthcare providers. In the event of a less-than-optimum outcome or emergent situation, the team players who respect each other are more supportive of each other and less likely to focus on anyone’s shortcomings. In today’s age of social media, it is more important than ever to stand firm in professionalism. Physicians should be steadfast in their resolve to remind society of the heroic efforts they make each day and not give reason for pause. If confronted with the unpleasant experience of a healthcare liability suit, a person’s perception of you may be more important than ever imagined.

“How you act is who you want to be. How you react is who you are.” - G. Mead

[1] Names and identifying details have been changed for confidentiality

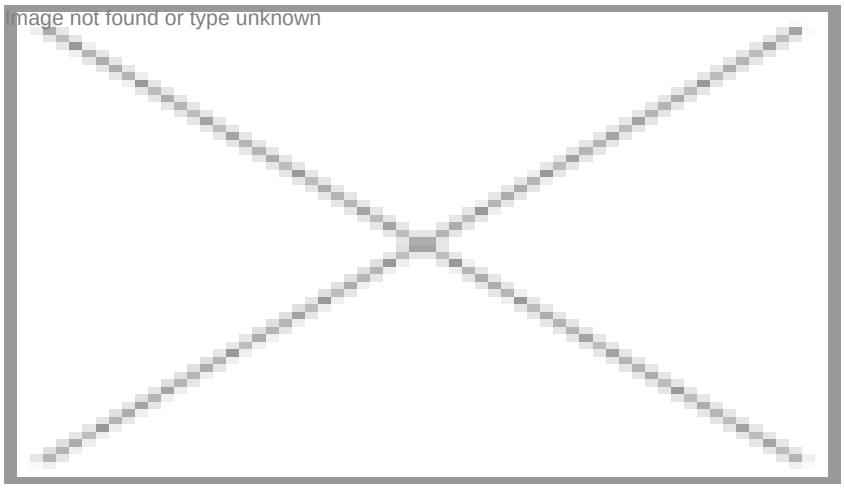
Government Releases Medicare Proposed Rule for 2019

By Elizabeth Woodcock, MBA, FACMPE, CPC

Choosing the appropriate level of an evaluation and management (E/M) codes is a daily occurrence for providers, but it's no easy task. The "correct" code for an E/M is dictated by two guiding principles – the 1995 and the 1997 Documentation Guidelines; providers must select one or the other. Both have spawned a multitude of reference tables, grids, and other "cheat" sheets to confirm that the elements of the encounter are performed in compliance with the guidelines.

In 2017, the Centers for Medicare and Medicaid Services (CMS) announced that they would launch a study of the challenges related to E/M documentation; the results were released last month in the CY 2019 Physician Fee Schedule Proposed Rule.

Declaring that the existing 10 codes for new and established patient visits are "outdated," CMS proposed a single, blended rate for 99202 through 99205 and another one for 99212 through 99215. The collapsed established patient code would be reimbursed at the national rate of $93, while the new patient rate would be $135. While the concept is arguably a good one, the proposed rates may give providers pause. (See table below).



In addition to the proposed rates, CMS recommends a softening of requirements related to key elements of the code to include the fact that providers would not be obliged to re-record the history and physical, or the chief complaint. Instead, the provider could

document that he or she reviewed, updated and verified the information, thus changing the focus on documenting that which has changed.

Providers are permitted to continue to use the 1995 or 1997 guidelines, but could instead select only medical decision making or the time spent face-to-face with the patient to support the choice of the appropriate code. This is in addition to documentation that would justify the medical necessity of the visit. The framework for the new plan would be a minimum documentation standard where providers would need only to document the information to support a level two E/M visit.

In the fact sheet issued with the proposal, CMS summarizes: “Practitioners could choose to document additional information for clinical, legal, operational or other purposes, and we anticipate that for those reasons, they would continue generally to document medical record information consistent with the level of care furnished. However, we would only require documentation to support the medical necessity of the visit and associated with the current level 2 CPT visit code.”

In addition to these “blended” codes, CMS recommends:

- A multiple procedure adjustment of 50 percent to the lowest value service that is furnished on the same day as a separately identifiable E/M.
- An add-on CPT code for use with primary care office visits, offering an additional ~$5; the code proposed is GPC1X, “*visit complexity inherent to evaluation and management associated with primary medical care services*.”
- A similar add-on code with a proposed ~$9 in reimbursement for office visits performed by certain specialties; the code GCG0X could be used for “*visit complexity inherent to evaluation and management associated with Allergy/Immunology, Cardiology, Endocrinology, Hematology/Oncology, Interventional Pain Management-Centered Care, Neurology, Obstetrics/Gynecology, Otolaryngology, Rheumatology, or Urology*.”
- An add-on code applicable for a 30-minute prolonged E/M visit.
- Removal of the requirement to justify the medical necessity of a home visit in lieu of an office visit.
- Elimination of the policy that prevents payment for same-day E/M visits by multiple providers in the same specialty within a group practice.

Virtual care was also in the spotlight in CMS' proposal, with the federal agency recommending payment to providers for "brief, non-face-to-face assessment via communication technology," as well as "evaluation of patient-submitted photos or recorded video." CMS elaborates that the photos or recorded video can be "conducted via pre-recorded 'store and forward' video or image technology to assess whether a visit is needed." The proposed CPT codes are GVCI1 and GRAS1, respectively. CMS is also recommending separate payment for "Chronic Care Remote Physiologic Monitoring" and "Interprofessional Internet Consultation."

For more information on the E/M and virtual care proposal, CMS provides a quick reference guide to these changes.

Although E/M documentation changes and virtual care were in the spotlight, the CY 2019 Physician Fee Schedule Proposed Rule incorporated many other recommendations, to include:

- Reducing the quality measure set for the Medicare Shared Savings Program's Accountable Care Organizations from 31 to 24;
- Dropping the drug payment add-on to three percent for wholesale acquisition costs (WAC)-based payments for new Part B drugs, instead of the current six percent;
- Eliminating the functional status reporting requirements for outpatient therapy; and
- Softening the requirement related to the "personal supervision" requirement for radiology technicians.

Not surprisingly, CMS is also proposing more changes to the Quality Payment Program, declaring a need to overhaul the "promoting interoperability" criteria. (This is CMS' new name for the "meaningful use" standards, which was subsequently named "advancing care information"; these have been replaced by the term "promoting interoperability.")

At present, these proposals are simply on the table for consideration. CMS will release the "final" word for 2019 in early November. Once the government's finalized plan is in place, we will report on it in The Sentinel.

For a full text of the 665-page proposed rule, click here.

Best Practices for Handling Missed Appointments

By Julie Loomis, RN, JD

Medical practices are often challenged with how to handle a missed appointment 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 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. It may be necessary to warn the patient of possible discharge from the medical practice for repeated missed appointments.

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 corresponds with the address given by the patient and if the post office provides a new address, 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, the treating provider may take steps to discharge the patient from the medical practice. Please consult an SVMIC claims attorney for assistance by calling 800-342-2239 or 615-377-1999.

The Mutual Value Plan is Here: Have You Opted In?

By

SVMIC is excited to launch the Mutual Value Plan® (MVP), a program designed to reward and thank our doctors for their long-term commitment to SVMIC.

The MVP is a new benefit for our insured doctors, created to allow the company to set aside funds over time which are then paid to policyholders upon retirement. Generally speaking, all individually insured SVMIC physicians with an active professional liability policy are eligible to participate in the MVP (be sure to read the Terms and Conditions for full eligibility specifics). Policyholders may be full-time or part-time and must individually opt-in to the plan.

Here's how it works – when you enroll in MVP, we'll fund your account with roughly a year's premium. Accounts will be funded, and initial allocations will be posted to the MVP account on the last day of the calendar quarter of enrollment. The accounts will grow by future quarterly allocations, determined annually by SVMIC's Board of Directors. As long as a policyholder continues to meet eligibility requirements, the account will continue to grow. Account balances will be available via the SVMIC website. Distribution will be paid in a lump sum check to the retired policyholder or his/her estate.

In order to receive a full distribution, a policyholder must have been in the MVP for at least five continuous years, and have permanently ceased the practice of medicine as a result of retirement, permanent disability, or death. Policyholders who have not been enrolled in the MVP for at least five years may have their distributions pro-rated. In the case of retirement, the policyholder must be at least 50 years of age in order to receive a distribution. Policyholders who leave SVMIC for any other reason will forefeit their account balance. The MVP is fully funded by SVMIC. There is no cost to policyholders.

In order to enroll, make sure you have an active email address and head over to www.svmic.com/mvp. If you have any questions, please email us at ContactSVMIC@svmic.com or call 800.342.2239

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