If You Order a Test, Follow Up On It

Peggy Sue White* was a busy lady. At 73 years of age, she was described by her husband of 57 years as his “whole world.” They had seven children together, 19 grandchildren and 11 great-grandchildren. She took care of him due to his poor health, made his doctor appointments and attended the appointments with him. She gave him his medicine and kept him on schedule. She did the grocery shopping, cooked the meals, helped him with his bath, washed the clothes and cleaned the house. And, importantly, she listened to his worries and helped him make decisions, while helping him provide advice to their children and grandchildren. She paid the bills, balanced the check book and monitored the bank account. She did almost everything in this household.

In the midst of all this activity, Peggy Sue developed back pain. As a long-time patient of Dr. William Steele, she was under treatment for coronary artery disease and high blood pressure. Back in 2007, she had undergone a CT scan of the chest (without contrast) and was found to have a significantly elevated calcium scoring index and was diagnosed with non-symptomatic left main, left anterior descending, and circumflex coronary artery disease. Then, in March of 2013, Dr. Steele ordered a stress test and cardiology referral. After extensive testing, the cardiologist found nothing significant. With this history, Peggy Sue presented to Dr. Steele with complaints of back pain in 2014. He had knowledge of these findings and considered them during the office visit.

Dr. Steele was aware that Peggy Sue disliked taking medicine and was known to be reluctant to take it as prescribed. At her appointment that Friday, which happened to be Good Friday, she described pain in her back that did not radiate to her chest, but activities such as bending over and reaching exacerbated the discomfort. Dr. Steele did a careful examination and documented that Ms. White complained of upper thoracic chest pain for the past four days that was described as both sharp and aching. It radiated into her arms. The patient was tender to palpation and seemed to have spasm in her neck. In addition, the patient had posterior tenderness along the thoracic spine, with tenderness spreading from T2 to T5. Dr. Steele ordered thoracic spine x-rays, PA and lateral chest x-rays. Dr. Steele felt that the patient’s symptoms were related to an exacerbation of her chronic back pain, but he ordered an EKG out of an abundance of caution. It was later noted that the EKG was performed with the patient’s medical record number on the tracing, but not her name, and according to the medical record, it was performed on a date that was in error. Dr. Steele did not see the EKG the afternoon it was ordered, and the office was closed over the weekend. On the following Monday, Dr. Steele was notified that the patient’s chest x-ray and spine films were interpreted as negative or nonrevealing, but the EKG showed significant injury pattern. Dr. Steele could see that the findings were virtually

diagnostic of an acute myocardial infarction. He received the EKG report on Monday morning after his nurse discovered it lying face down on her desk where it had been placed, presumably, on Friday afternoon after he and his nurse had left early for the holiday weekend.

Dr. Steele immediately called Mrs. White to report the results of the tests and was told that the patient had expired the day before. Mr. White told him that she had experienced more chest pain, along with nausea and shortness of breath, on the previous morning, and that the patient died shortly thereafter.

In the summer of 2015, a suit was filed by the surviving husband, Mr. White, against Dr. Steele, his group, the EKG lab and the hospital who owned the lab. In the complaint, Mr. White alleged that his wife was allowed to leave the facility without knowing the results of her EKG, and that Dr. Steele failed to timely follow up on the results of the test. He alleged that Dr. Steele failed to recognize and appreciate the seriousness of Mrs. White's condition. He also alleged that the defendant lab and the hospital failed to timely notify Dr. Steele of Mrs. White's abnormal EKG results on the same day of the test. He also stated that Mrs. White was never notified of her abnormal EKG, and as a direct result, Mrs. White sustained a fatal cardiac event.

Dr. Steele expressed deep regret about Mrs. White's death under the circumstances. He explained that, according to typical office procedure, he would send a patient to the lab located in the same building as his office. The lab would perform the procedure or test that he ordered. And then, the result, especially if abnormal, would be called in to him or brought down to his office and given to his nurse. On this Friday, however, he and his nurse left early for the holiday weekend. Since Mrs. White had come in for her office visit early in the day on Friday, an MI was low on his differential, and she had gone to the lab for her EKG early in the morning, he made the assumption that the result was normal. He had not called to check on the results before leaving for the day.

Dr. Steele's defense counsel was not able to locate an expert who could support his care in this instance. However, our potential experts understood Dr. Steele's predicament. He ordered the EKG to be thorough and thought the patient had a back strain. He was not expecting an abnormal finding. If the lab's procedures had been followed, the test results should have been taken to any other available doctor in the office. The physician receiving this information would have likely sent the patient to the ER for an assessment, and the events that led to this lawsuit would probably have never occurred . Unfortunately, once the lawsuit was filed, each of the defendants tried to explain how this event happened and how it was not his or her fault. In the end, counsel for Dr. Steele recommended that a reasonable settlement be attempted. Given the dynamics between the defendants, the negotiations were difficult and protracted, but a resolution by settlement was ultimately achieved by all of the defendants.

Providing good patient care is a team effort between physicians, staff, hospitals, labs, and patients. In this scenario, the abnormal test result was left on a physician's desk after he and his nurse had left the office for the weekend. This unfortunate event was due to

breakdown in the normal procedures and should not have happened. In the face of an adverse outcome, processes and procedures are reviewed, analyzed, and corrective measures implemented to demonstrate an improvement. All of those involved in this situation, through this mishandling of the transmission of one test result, were devastated by the outcome because the patient did not receive a timely assessment and treatment. In the end, everyone lost. Take the time to evaluate your office processes so that you can provide your patients with the best possible care no matter the circumstances.

*All names have been changed

Government Shutdown Averted

The Bipartisan Budget Act of 2018 was expected to focus on immigration, however, healthcare was the prevailing theme of the law that was passed on February 9, 2018. Highlights for medical practices include:

- The elimination of the Independent Payment Advisory Board (IPAB), a group of 15 stakeholders who were empowered to take action to “save” money for Medicare; although the IPAB, which was created under the Affordable Care Act, had never even convened, the potential challenges from a board deciding the future of Medicare reimbursement had left many physicians on edge.
- A decade of funding for the Children’s Health Insurance Program; further, community health centers – federally funded quality health centers and rural health clinics – received not only an extension of funding, but more than a 10% boost.
- An extension of the Work Geographic Practice Cost Index (GPCI) floor; a key component of the Medicare formula, this has positive implications for physicians practicing in more than 20 states, including Tennessee. Although the reimbursement boost won’t be enormous – Tennessee, for example, will rise from 0.976 to 1.0 – it will positively impact *every* procedure code billed to Medicare.
- The permanent repeal of the Medicare payment caps for outpatient therapy services, to include physical and occupational therapies, as well as speech pathology.
- A revision to the Merit-based Incentive Payment System, which was scheduled to impose a 30% performance score on eligible clinicians based on cost in 2019; the law extends 2018’s 10% scoring methodology for three more years although there is flexibility extended to the Centers for Medicare & Medicaid Services: “not less than 10 percent and not more than 30 percent.”
- A pledge to evaluate reimbursement for *longitudinal* chronic care management, presumably expanding the coverage for transitional care and chronic care management; this study, however, will consume the next 18 months so reimbursement opportunities are not here yet, but on the horizon.

Finally, telehealth reimbursement is further expanded, adding telehealth benefits to Medicare Advantage patients, as well as expanding payment opportunities for accountable care organizations (ACOs) for telehealth.

SVMIC Launches Podcast Series

This month SVMIC is proud to introduce our Podcast series, “Your Practice Made Perfect,” to our lineup of educational resources. The series idea was born after conducting research with medical students and residents and discovering many of these students seek out, listen to and enjoy Podcasts for entertainment and learning. We found tomorrow’s doctors are excited to begin their careers and make a difference in people’s lives, yet they often feel unprepared on how to handle the non-clinical side of their careers. They love science and caring for people but could use help with the business, financial, and legal aspects of medicine along with navigating a malpractice policy. They are also interested in mentoring from seasoned, practicing physicians who have been where they are and are well acquainted with the challenges they face. A keen interest in learning what can go wrong and what happens when it does so was a dominant theme amongst the groups.

Armed with this information, SVMIC set out to create a Podcast series to share information with these students and all practicing medical professionals. SVMIC is a company built around experts in varying topics, and we realized we could utilize Podcasts as an opportunity to share our knowledge expertise in the medical field. The series covers interviews with experienced physicians, compliance, malpractice and prescribing experts and addresses a wide range of topics from how to negotiate a contract to tips on attempting to obtain a work-life balance as a busy physician. Our robust collection of Closed Claim episodes educates listeners on the details and outcomes of adverse medical events. Other subjects include the nation’s opioid crisis, physician burnout, cybersecurity and clinical issues. Each episode is around 20 minutes in length and structured to appeal to a wide audience.

Podcasts are a conducive and economical way to broadly disseminate information. Similar to a radio broadcast, listeners can tune in on their own time and receive succinct information on a focused topic. A Podcast provides a busy individual a chance to tune in to helpful or entertaining information without sitting down or setting aside special time. You don’t have to spend hours in front a screen to learn something new, and they provide a human connection from the speaker to the listener. People are busy in general, but medical students, residents and medical professionals are always on the go. Podcast episodes are streamed or downloaded on a mobile device, making them convenient to listen to while spending time in the car or at the gym.

Brian Fortenberry, Assistant Vice President of Underwriting at SVMIC, hosts the series. Fortenberry brings a diverse portfolio of experience to the mic, having spent more than 10 years in broadcast media and the clinical side of medicine prior to joining SVMIC in 2007.

Four episodes are available now; beginning in March, one episode will be released every Friday through 2018. Listen and subscribe via the Podcasts app on an iPhone, the Google

Play Music app on an Android device and here on SVMIC's website.

The Patient Experience

As healthcare evolves, so do patients' expectations. Payers are changing reimbursement strategies to focus on value-based care, therefore patients' experiences and subsequent reviews of those experiences can affect the practice's level of reimbursement. Understanding patients' opinions and expectations is critical to a successful practice. Unique to the industry, healthcare is built on a platform of trust and communication. Patients need to trust their physician and the physician's staff. Much of that trust emanates from effective communication. Establishing and maintaining a trusting relationship with patients is a challenging and critical necessity for medical practices seeking to create a positive patient experience.

Aside from reimbursement implications, there are a number of practical reasons to focus on patient experience. Negative experiences create negative marketing and can set the stage for litigation if there is an adverse outcome. Patients who understand and engage in their care do better statistically than those who do not. Those patients who do not understand their condition and care instructions can create inefficiencies in the practice with repeated phone calls and unnecessary visits. Such inefficiencies can be costly for a practice in a value-based care reimbursement scenario.

Why are trust and communication important?

- It is the core of service in healthcare
- Patients disclose more information to physicians they trust
- Trust leads to patient retention, positive word of mouth and improved patient outcomes
- A lack of trust and poor communication can lead to:
    - Animosity between patients and physicians
    - Reduced patient satisfaction and experience
    - Non-compliance
    - Increased risk of liability exposure

What steps can I take to build trust? Establish a level of comfort with all patients by:

- Connecting to the patient and take the time to get to know him/her
- Explaining to the patient what is going to happen, why you are doing what you are doing and/or why you are not doing something else
- Do what you say you will do, when you say you will do it
- Knowing the patient ultimately helps to shorten subsequent office visits

Why are first impressions important?

- Patients evaluate the quality of medical care based on the courtesy, helpfulness, promptness, cleanliness of the office and bathrooms and consistent attitude of friendliness of all staff
- Consider how a patient might view the following:
    - How they are treated by the staff in person and on the phone
    - How the office looks
    - How other patients are treated by staff
    - If they sense stress or discontent among the staff or notice staff turnover
    - Overhearing information and/or disparaging comments about other patients and/or staff
    - Seeing information about another patient on a computer screen left on or paper left laying around

How can a good first impression be created?

- Practice good basic manners
    - Knock before entering a room
    - Introduce yourself
    - Address patients by their formal title, unless the patient requests a first name basis
    - Give patients and their family your complete attention
- Staff should routinely monitor office appearance and efficiency
    - The building and parking lot should well lit and maintained
    - The office and restrooms should clean and stocked
    - Keep furnishings in good repair, up to date and suitable for patient populations - elderly, children, handicapped, obese, etc.
    - Ensure appropriate accessibility for the impaired or handicapped
    - Cover electrical outlets if children are present
    - Prescreened reading material should be current and of interest to your patient population
- Exam rooms should provide:
    - Privacy - exam tables positioned out of view of opened door
    - Comfortable temperature
    - Adequate and appropriate reading material
    - Confidentiality - be aware of exam room walls that are thin enough to overhear private conversations in adjacent rooms

How can communication be improved?

- Welcome letter, new patient brochure or website
    - Outlines services, policies and providers at your office
    - Provides educational resources
    - Allows patients to access and complete paperwork needed for office visit
- Face to Face Communication:

    - Everyone who approaches the front desk should be acknowledged even if only with a smile and a nod from the receptionist on the phone
    - Make arrangements for privacy to discuss confidential patient matters (i.e., demographics, financial and medical)
    - Non-verbal communication can communicate attention and respect
        - Exhibit courteous treatment regardless of race, ethnic origin, sexual orientation, economic or financial status
        - Maintain eye contact
        - Sit at patient's level when talking to them
        - Avoid looking at your watch and keeping one hand on the doorknob
- Verbal communication
    - Establish a communication pattern in which the patient feels that his comments are valuable
    - Practice reflective listening - occasionally repeat something a patient says to demonstrate you are listening
    - Have some idea why the patient is there before entering the exam room, determine his/her concerns and prioritize them, share those priorities
    - Use language appropriate to the patient's level of understanding
        - Use lay terms, minimizing use of medical terminology
        - Use the teach-back method and open-ended questions (who, what, when, where, why and how) to confirm patient understanding
    - Involve the patient in their care and treatment
        - If necessary, include the patient's significant other in the education and information where appropriate and approved by the patient
        - Establish realistic expectations
        - Minimize distractions when interacting with patients
    - Set expectations for telephone and scheduling staff:
        - Be prepared
        - Smile
        - Answer promptly - by third of fourth ring maximum
        - Answer with name, role and greeting
        - Speak slowly and clearly
        - No food or gum
        - Ask permission for hold - advise how long the hold may be
        - Notify caller before transferring
        - Get as much information as possible for messages
        - Understand if you are calling a patient, he or she may be busy
        - Be courteous, responsibe and accurate with instructions
        - Phone trees, answering machines and on-call services should let patients know what to do in case of emergency

How your staff treats your patients is a reflection of your culture

Patients are extremely forgiving if they are treated in a manner that lets them know you care. Creating an environment of trust allows staff to focus on your patients and lets them

know you care. How a patient feels about a practice can be just as important as medical expertise. This connection between, patient, staff and physician can not only make a critical difference in the patient's evaluation of his or her care and experience but his or her outcome as well.

Measuring Patient Experience

Many practices choose to measure patient satisfaction in addition to and/or separate from payer requirements. Satisfaction seeks to measure the happiness of a patient, which is important but is not the same as patient experience. The focus should be on measuring patient experience, which is a measurement of the patient's perception and understanding of his or her care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey (CG-CAHPS) provides a tool that includes standardized instruments for adults and children. It can be used in both primary care and specialty care settings. The questionnaire may be customized with the addition of supplemental items by the practice. For example, you may want to also ask the same questions about the helpfulness, courtesy and respect of the nursing staff (already included in the sample survey for clerks and receptionists). You could ask additional questions about the ease of the website, general office environment, directions, parking, etc. Forthe survey and supplemental questions, visit this link for additional information and guidance on the tool and its use. Remember, while you may not agree with the patient's perception, it is factual to him or her and created in part based on the experience your staff and you provided.

Get the Reimbursement You Deserve

How much do you know - and truly understand - about your allowables? This is the term for the discounted price to which you agree as a participating provider for an insurance company. This price is not what the payer reimburses you, but rather the rate you agree to accept as payment in full based on the patient's coverage. It may, for example, be collected from both the insurer as well as the patient in the form of a coinsurance.

Accepting the discounted rate means that you must take an adjustment – a write-off - based on the portion of your charge in excess of that allowable. If every insurer had a single rate, this might be a simple equation to interpret. Not only does every procedure code have a different allowable, but insurers may offer multiple health plans with varying schedules of allowables for each product. To make matters worse, many payers fail to disclose their allowable amounts.

In the business office, it's not uncommon to encounter a lack of understanding about this phenomenon. Ask most billers why the allowable is $47 for a particular service from one health plan, and $92 from another; the answer is often: "…because that's what it [the payer's remittance] says." However, I ask, is either rate truly a reflection of your contract with the payer?Whether it's the complexity, lack of transparency or perhaps ignorance, too many medical practices sweep this issue under the rug, failing to understand the potential reimbursement that they have earned. Consider: this would be the same as Walmart having no idea about their price for a loaf of bread, a gallon of milk or a pair of jeans!

Defining the reimbursement that you deserve to be paid is essential to operating a successful medical practice. If this concept of "allowables" is news to you – or you recognize that there may be opportunity for improvement, the following tips can help you better understand allowables in your practice:

Determine every payer's allowables. Ultimately, you have to request this information if you want it. If the payer tries to claim that there are too many variations, then ask for the allowable related to procedure codes representing the majority of your total reimbursement. This will probably be between 25 and 50 procedure codes per specialty. Don't settle for "110% of Medicare." This leaves too many unanswered questions such as: "Which year?" "Is sequestration applied?" and so forth. Provide the specific procedure codes, and ask each payer to record the specific allowables for each plan that they offer in your market. Be prepared; you will likely have to ask more than once, but don't give up. The exception is Medicare; look up the allowables (for free!) at this link. Medicare rates vary based on geography, so be sure to choose the location of your practice. Many Medicaid and

Workers' Compensation schedules are also available online.

Understand pricing. Allowables aren't what you get paid from payers. Thinking that is what you get paid is a common mistake. Rather, an allowable simply represents the maximum that your practice is allowed to collect . In addition to financial contribution from a secondary payer, if applicable, the allowable also includes copayments, unmet deductibles and other out-of-pocket financial responsibility. This means that you must collect what is owed by patients in order to receive the reimbursement that you deserve. On the whole, failure to collect from patients is the chief reason most practices collect less than 100 percent of their allowables. As the burden of financial responsibility has shifted from payer to patient over the past few years, the "net value" of the allowable has decreased. Take the opportunity to reduce the likelihood of this trend adversely impacting your practice. And, remember, without knowing what those allowables are you'll never be on track to be paid accurately.

Increase automation. To avoid mistakes and stay abreast of your allowables, automate the evaluation of payment gaps. As remittances are posted, most practice management systems provide for a comparison of the expected rate. However, this variance reporting requires your practice to load and maintain the contracted allowables.

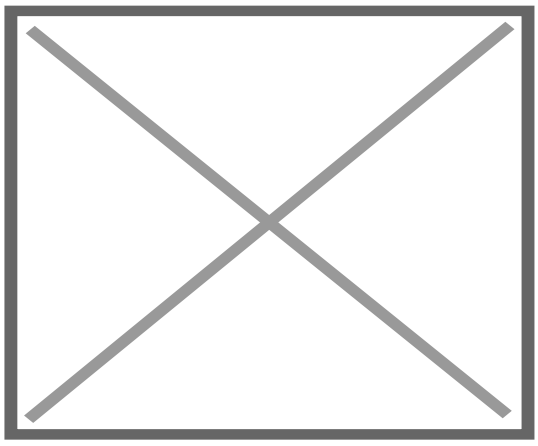
Take action. Review the payment variance report on a weekly basis, and more often if you're a high-volume practice or have experienced problems. If you determine that you're not being paid according to your contracted rate, it's time to take action. Call the payer to report the problem. Follow up in writing, outlining the variance and attaching copies of the remittances as proof of the problem, with all protected health information blacked out. Be diligent in your efforts, reporting first to your designated representative, then moving up the payer's organizational chain from there. Get the state insurance commissioner involved if the payer is not responsive.

Don't be left in the dark; understanding allowables provides the framework for successful billing and collections. In the pursuit of well-deserved reimbursement, knowledge is power.

Reducing Liability Exposure In the Physician Office

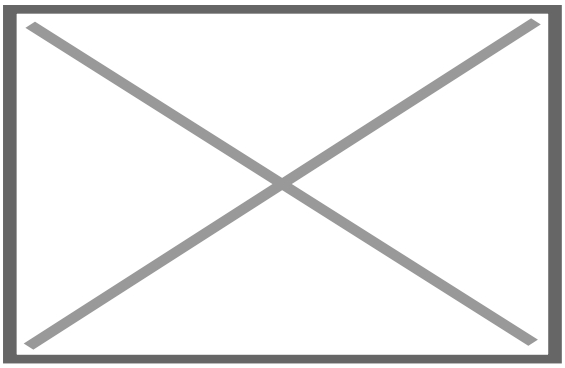
As healthcare has shifted more toward the outpatient setting, the complexity and acuity of patients seen in that setting has intensified. As noted in MGMA's Patient Safety and Quality Advisory Committee White Paper, "While most ambulatory care is less technically complex than inpatient care, it is often logistically more complicated. An episode of ambulatory care often requires communication and coordination among a number of clinicians, laboratories and imaging facilities, as well as the patient and the family, across different sites… Another unique component of ambulatory care is reliance on the patient and/or the patient's family to seek treatment and carry out much of his or her own clinical management." [1]

SVMIC provides on-site risk evaluation services to policyholders, at their request, to help them identify and address the unique risks in the outpatient setting. In our efforts to provide current, pertinent and comprehensive recommendations, SVMIC conducts closed claim analysis to identify primary allegations and contributing factors. In a review of claims with a paid loss in the last 5 years, 42% occurred in an outpatient setting.



Most Common Allegation

Our data is similar to national data, which reveals that a delay in diagnosis and/or treatment is the number one allegation in the ambulatory setting. As seen in the chart below, 46% of paid closed claims were attributable to diagnostic/management error and 24% were attributable to medication prescribing or management thereof.



Most Common Contributing Factors

There are multiple national studies which have identified the most commonly occurring errors related to missed diagnosis and delayed treatment, including incomplete medical history and examination, medication management, test ordering and review, delay in treatment of abnormal test results, mishandling of patient requests and information in the record, and suboptimal coordination of care across different healthcare facilities and between providers. [2][3] [4][5][6]

These factors were also present in the closed claim data that we reviewed, which demonstrates that adverse outcomes are often not due to clinical competency issues but rather a breakdown in processes or communication. Such was the case in the following example:

In follow-up to a mom's complaint of "staring spells" during her teenage daughter's well checkup, an EEG was ordered. The mother called the office for results one week after the EEG was performed and was told the results were not back yet. Four days later, the hospital contacted the pediatrician regarding the abnormal results and the pediatrician ordered a neurology consult. The office attempted to call mother to notify her of such. Documentation was limited to "left a voice message for mom to call back". The office did not hear back from the mother and made no further attempts to contact her. Additionally, due to a process breakdown, no referral was arranged. Nine months later, the teenager arrested and resuscitation was unsuccessful. The failure to make additional attempts to contact the mother and failure to follow-up on the referral to neurology hindered the ability to defend the case. The case was settled.

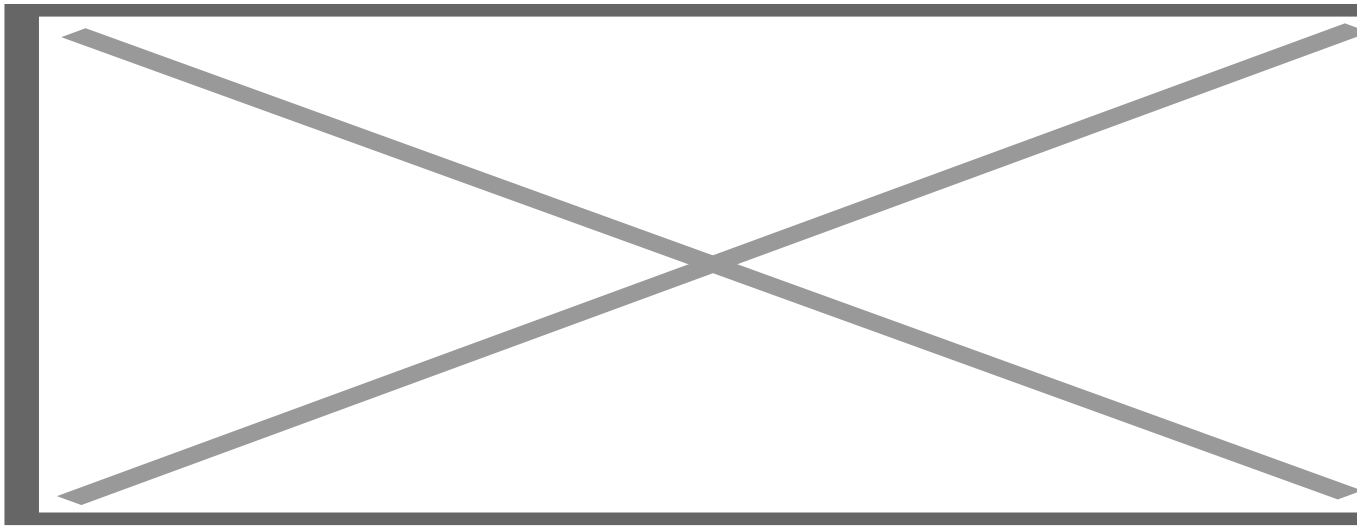
On-site Risk Opportunity Findings:

In the on-site risk evaluation visits, conducted by SVMIC's legal nurse consultants, the focus is on the most significant areas of liability exposure (delay in diagnosis/treatment and medication related errors) and the critical processes that can influence those. The hard part for practices is not motivating physicians and staff to improve patient safety, but rather developing and maintaining consistent systems and processes in the midst of a busy practice.

Most Significant Risk Opportunities Identified In Our Onsite Visits Over the Last Five Years:

1. Close the loop with test results by adopting consistently used tracking systems

The Agency for Healthcare Research and Quality (AHRQ) diagram identifies best practices with ordered tests, i.e. a process that ensures test results have been received and reviewed in a timely manner, communicated to the patient, and follow-up treatment (if indicated) provided, including the documentation thereof. This step-by-step process is known as a “tracking system”.



Almost 90% of providers undergoing an on-site risk assessment have a system to track lab and diagnostic test results, most of whom utilize electronic tracking. Those who do not have effective systems in place 1) attempt to rely on memory, 2) have made the assumption that a system is unnecessary based on their experience that tests often return without follow-up or 3) rely on a follow-up visit as the trigger to review test results without being aware of no-shows and cancellations. Likewise, the great majority of providers report reviewing all test results and documenting having done so. Patient notification of test results is essential (as is documentation of the notification), even those that are normal. Most providers reported to us that they notify patients of all test results, including the normal results. They understood the importance of involving the patient in their care and the additional safety net that patients can provide when told “call if no results received”.

2. Improve continuity of care between healthcare facilities and providers

Effective communication is the key to ensuring continuity of care. Many of the specialists we spoke with have a consistent process whereby their staff notifies the referring physician if the patient fails to present for the first appointment. By contrast, our findings revealed that referring providers often do not consistently have a process in place to ensure the

consultant's report has been received.

With regard to hospital discharges, most physicians had a mechanism in place to ensure patients had a post-discharge appointment following their hospitalization and understood the possible risk of the patient being "lost" by virtue of the fact that he/she is not within the office confines at the time of discharge.

3. Improve accurate documentation of medication and monitoring

The sheer volume of prescriptions written in the outpatient setting contributes to increased potential for medication- related adverse outcomes. SVMIC data reveals that medication related issues are the second most common claim in the physician office setting. Medication reconciliation between providers and facilities can be especially challenging. Our record review showed the consistent presence of a medication/allergy list. Practice managers typically report that staff takes a medication history at each visit prior to being seen by the provider. Of note, providers infrequently documented the patient's self-reported use of illegal substances or misuse of controlled substances, both of which are important areas to explore with the patient prior to prescribing medications.

While providers reported frequently educating patients about the importance of high-risk or newly prescribed medications, documentation of this was infrequently seen. Practices that frequently prescribe high-risk medications acknowledged the importance of tracking systems to ensure the patient is seen in follow-up and medication is appropriately monitored.

4. Maintain complete, accurate and timely documentation

The importance of maintaining a well-documented medical record cannot be overstated from both a patient care and a risk management standpoint. Inadequate documentation can negatively impact the ability to defend the care provided to a patient.

Our record review revealed the following elements to be frequently present: complete medical history, allergy/medication list, physical exam, and diagnosis/treatment plan. Specific recommendations for screening tests were not consistently present. A procedure consent discussion was usually documented within the office note; documentation ranged from "risks and benefits discussed" to a comprehensive listing of the more common and most serious risks, even if rare.

With the steady adoption of EHR over the last five years, associated risks have risen including templated notes that may not reflect the clinical picture or clearly describe the treatment plan. Additionally, timeliness of note completion within 48 hours has been challenging for some providers. While staff typically reported documentation of all phone calls in which clinical information was exchanged, the documentation of these patient calls was often nondescript such as "called patient" or "left message". Many providers indicated that they documented only "the most important" after hour phone calls or in some cases, did not document them at all.

Keep in mind that good documentation is the best defense against liability should a complication arise. Absent or incomplete documentation can seriously undermine efforts to defend the medical care if a lawsuit is filed.

Action You Can Take Now To Address The Most Significant Exposures:

- Providers and practice managers should promote a culture of safety and teamwork. Educate staff on their role in improving patient safety.
- Evaluate all of your tracking systems for effectiveness and consistent use by all providers. Track all tests from all facilities/lab vendors, not just those that interface with your EHR.
- Notify patients of all test results. Instruct them to call you if they have not received the results within a specified time period.
- Consistently follow up on referrals. If you are a specialist, notify the referring physician if the patient does not present. If you are the referring physician, follow-up to obtain the results from the consultant.
- Document the patient's full medical history, including social habits. Prioritize accurate documentation of medications. Train staff to take medication history with every visit and to avoid yes/no questions, such as "are all your medications the same?"
- When first initiating high-risk medication therapy, educate the patient to understand the indications for the medication, the potential risks and benefits, potential side effects and how to manage them. Consider using medication educational modules in your EHR or resources such as the one here. Document your education efforts in the medical record.
- Refer to the Electronic Health Record Self-Assessment at on our site to assist with the identification of EHR risks within your practice.
- Use the informed consent process as another opportunity to establish or solidify rapport. Provide the patient with adequate opportunity to ask questions. While the most serious risks for a procedure may be rare, it's important to include those in your discussion and documentation as well.
- Take the time to document all calls in which clinical information is exchanged, including who you spoke with and what information/instructions were given. SVMIC after-hour phone call pads are available at no charge. Additionally, technology is now available that can assist physicians in documenting phone calls after hours with encrypted software on mobile phones.
- To learn more about tracking and EHR documentation, The SVMIC Education Center to attend online courses, which are available for providers and staff.

If you would like a personalized risk evaluation of your practice, contact SVMIC and ask to speak with Risk Evaluation Services.

[1] Meeting the Challenge of Patient Safety in the Ambulatory Care Setting. Medical Group Management Association. Patient safety and Quality Advisory Committee White Paper. Available at : https://www.mgma.com/practice-resources/topics-overview/meeting-the-

challenge-of-patient-safety-in-the-ambulatory-care-setting

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