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Medical Risk Resource ADVISOR

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Mitigating Risk— Five Key Areas of Focus

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ProAssurance cannot instruct physicians or mid-level providers on clinical instructions or surgical techniques but we can offer guidance to help you mitigate risk. Here are five key areas to focus on that can help protect you and your practice.

Somewhat surprisingly, the FDA has only approved 10 healthcare apps as of July 26, 2016.

#1 › Use Technology with Caution

Healthcare looks very different than it did 25 years ago. Physicians are using tablets, smartphones, interactive apps, and several other electronic means to provide efficient healthcare to patients.

According to several sources, between 75 and 85 percent of physicians use a smartphone or tablet for professional purposes.[1] Uses include email, research, EMR entry, x-ray review, telehealth, and more. While electronic devices have many benefits, their use presents new risks.

Chief among these risk exposures is the increased possibility of a HIPAA violation. While a HIPAA violation is not the same as a malpractice claim, it can still negatively impact you and your practice, staff, and patients.

HIPAA concerns arise in several areas of electronic device use. Losing a device may allow an individual access to protected health information (PHI) stored on the device. If the device is not properly encrypted or secured, an individual may access PHI through apps, email, or hacking into a system using the device's connectivity.

Another risk arising from mobile electronic devices is app usage. There are approximately 26,000 healthcare apps available, and 7,400 of those apps are marketed to physicians.[2] Somewhat surprisingly, the FDA has only approved 10 healthcare apps as of July 26, 2016.[3]

One physician wrote about a blood pressure app he was using that gave inaccurate readings. When he contacted the app's developer, he was told the app was in the "beta-testing stage" and intended for "entertainment purposes only." Despite this information, the developer was selling the app to end-users—without any disclaimers or mention of its test status.[4]

Physicians and mid-level providers need to be vigilant when deciding whether to use certain apps. Research the app's usage and do preliminary testing to ensure its accuracy. We suggest using the app, then verifying the results with traditional testing until the physician is satisfied the app's results are accurate. Another suggestion is to contact the app's developer and request testing/clinical trial results on its accuracy.

Use of smartphones, tablets, laptops, etc., in healthcare becomes more mainstream every day. Be sure you are proactive in mitigating the accompanying risks. You may need to contact an IT security specialist to help ensure you are managing potential risks as effectively as possible.

[1] "Mobile Officially a Staple in the Doctor's Office," March 26, 2015, <http://www.emarketer.com/Article/Mobile-Officially-Staple-Doctors-Office/1012271>, accessed on October 11, 2016.

"Survey of physicians suggests tablets more useful than smartphones," June 12, 2013, <https://www.acponline.org/acp-newsroom/survey-of-physicians-suggests-tablets-more-useful-than-smartphones>, accessed on October 11, 2016.

[2] Sher, D, MD, "The big problem with mobile health apps," March 4, 2015, <http://www.medscape.com/viewarticle/840335>, accessed on October 13, 2016.

[3] "Mobile medicine resources: FDA approved apps," July 26, 2016, <http://beckerguides.wustl.edu/c.php?g=299564&p=2000997> , accessed on October 13, 2016.

[4] Sher, D, MD, op. cit.

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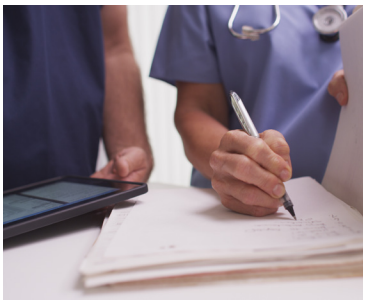


#2 › Track and Follow up on Your Tests

Missed or delayed diagnosis is one of the most often litigated allegations in medical malpractice.[5] These claims often result from tracking and follow-up procedure failures.

Lab testing is one of three key areas (the others are referrals to specialists and missed/canceled appointments) where tracking and follow-up are vitally important. A retrospective study researched the frequency of patients not being informed of test results concluding there was a 7.1 percent failure rate.[6] Tracking and follow-up procedural safeguards can be implemented and have a large impact on potential liability claims.

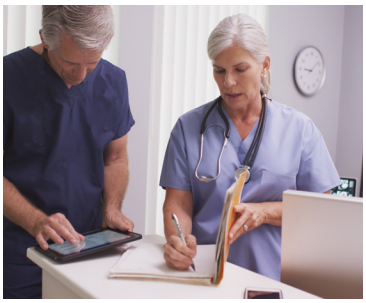
A reliable test tracking and follow-up system ensures the following steps occur:

1. **The test is performed.**
2. **The results are reported to the practice.**
3. **The results are made available to the ordering physician for review and sign-off.**
4. **The results are communicated to the patient.**
5. **The results are properly filed in the patient's chart.**
6. **The results are acted upon when necessary.**

Here are some suggestions for improving your process:

- **Route all test results to the ordering physician for review.** Procedures to ensure the ordering physician receives each and every test result can help lessen the risk of a result "falling through the cracks." Something as simple as a log book or email notification can help facilitate physician review.
- **Ask the ordering physician to review and sign off on each ordered test result.** Physicians order lab tests for medical reasons; we encourage physicians to sign or initial each test result following review.
- **Notify your patients.** Several practices notify patients only when there is an abnormal result. Some practices choose to send a letter for normal results and call the patient for abnormal results. Others call patients with all results. In today's technology-driven world, an email may be appropriate for normal results, or an email directing patients to a portal where results can be reviewed. Patient notification of all test results is advised—however your practice chooses to do so.

Ensuring all tests ordered by your physicians are handled in a consistent manner will help avoid tracking and follow-up errors.



#3 › Maintain Accurate Medical Records

A medical record is crucial to the defensibility of a case; occasionally it can be the biggest hurdle. The primary purpose of a medical record is to provide a complete and accurate description of the patient's medical history. This includes medical conditions, diagnoses, the care and treatment you provide, and results of such treatments. A well-documented medical record reflects all clinically relevant aspects of the patient's health and serves as an effective communication vehicle.

The medical record also has a critical secondary function: it is the most important piece of evidence in the successful defense of a medical professional liability claim. On average, a medical malpractice lawsuit takes five years to resolve.[7] Most physicians cannot recall specific patient encounters from several years ago—so it is important to have accurate, thorough, and timely documentation of all your patient encounters.

Good medical record documentation may help prevent a lawsuit. Your defense team may be able to disprove a patient's assertions if the physician has thoroughly and accurately documented the patient encounter.

Good medical record documentation includes, but is not limited to, the following elements:

1. **Legible** – If your handwriting is not legible, consider dictating your notes.
2. **Timely** – Most electronic medical record systems document the date and time of all entries. If you still use paper records, note the date and time of each entry, with an accompanying signature or initial. It is best to chart patient encounters either contemporaneously or shortly after the visit for more accurate and thorough documentation.

[5] "PIAA Closed Claims Comparative: A comprehensive analysis of medical professional liability data reported to the PIAA Data Sharing Project," 2015 Edition.

[6] Casalino, L.P., et al., "Frequency of Failure to Inform Patients of Clinically Significant Outpatient Test Results." Archives of Internal Medicine 169 (2009): 1123-9.

[7] Suszek A., "How long will it take to settle your medical malpractice case?" <http://www.alllaw.com/articles/nolo/medical-malpractice/how-long-settle.html>, accessed on October 31, 2016.

Additions, corrections, or addendums may be pertinent in certain situations, but we strongly discourage altering a medical record.

3. **Accurate** – Ensure your documentation accurately reflects what occurred during a patient encounter.
4. **Chronological** – Documentation is more easily understood when it is sequential by date and logical in process. We suggest using the SOAP (subjective, objective, assessment, plan) format, or something similar, when documenting patient encounters. A logical, clear thought process is compelling evidence to present to a jury.
5. **Thorough** – The old adage "if it's not documented, it didn't happen" still applies today. It is challenging to show something happened if there is no documentation to support that assertion.
6. **Specific and objective** – Make documentation as specific as possible (e.g. using actual measurements rather than descriptors such as "small" or "large" in size).

Additions, corrections, or addendums may be pertinent in certain situations, but we strongly discourage altering a medical record. It will destroy your credibility in the eyes of a jury and cast doubt on the legitimacy of the entire chart. Alterations include modifying accurate information for fraudulent or self-serving reasons.

To properly correct a written chart, strike a single line through incorrect information, leaving it readable. Then make the correction or addition as needed. Be sure to authenticate the change with a time and date, along with your initials or signature. In the event of litigation, be prepared to be questioned about any changes made to the patient's chart—especially if they occurred after the incident in question or suit was filed.

Follow the same authentication principles in electronic records; consider using a "strikethrough" function rather than deleting information. We strongly discourage making any corrections or additions to a medical record after a claim or lawsuit has been filed—or after receiving notice a claim or lawsuit may be filed. These actions will likely be viewed as self-serving and could severely undermine your defense.

#4 › Set and Review Policies and Procedures

A policy and procedure manual is an important tool for defining practice operations. In well-run practices, there is one set of rules every staff member understands and follows. The alternative is risky—procedures that vary from physician to physician or between staff members make it easy for errors or omissions to occur.

Develop a comprehensive manual of specific policies and procedures that explains how tasks are performed in your office, and make it readily available to all staff. It's important for staff to review and initial that they have read and are aware of these policies and procedures. It also is prudent for the physician (or a committee of physicians and staff members) to annually review policies and procedures.

The following is a list of suggested topics to address in your policies and procedures manual:

1. **Clinical Protocols/Patient Care**
2. **Patient Relations and Confidentiality**
3. **Health Information Management (Medical Records)**
4. **Laboratory**
5. **Radiology**
6. **Appointment Scheduling**
7. **Infection Control**
8. **Human Resources**
9. **Practice Operations**
10. **Special Procedures**
11. **Safety**

You may need to add or subtract certain topics to best address the specific areas of your practice.

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Mitigating Risk—Five Key Areas of Focus

While the risk of a medical malpractice claim can never be eliminated, the information provided herein will help you reduce your practice's risk of a claim.

If you have a specific question regarding your practice, please contact our Risk Resource Department at 844-223-9648 and speak with a Risk Resource Advisor.

#5 › Keep Your Team Trained and Informed

Office staff is a critical component of a medical practice. Patients often have more interaction with staff than physicians. Properly trained and educated staff can be strong protection against a professional liability claim. We offer the following risk tips for office staff issues:

- Prepare written job descriptions for all staff. Review each staff member's job description at his or her annual performance evaluation to determine whether the description accurately reflects the individual's responsibilities and capabilities.
- Ensure each staff member works within the boundaries of state laws regarding appropriate job functions.
- Provide clear instructions to your staff on the amount and type of advice they may relay to patients and limitations on such advice.
- Establish a formal orientation period for new employees. Include a review of administrative practices, emergency medical procedures, and clinical skills and responsibilities.
- Establish procedures to ensure professional staff are credentialed.
- Educate all employees on patient confidentiality and have them sign a confidentiality agreement annually.
- Document employee training, including clinical competency, credentialing, performance evaluations, and annual reviews in employees' personnel files.
- Conduct regular staff meetings with designated agendas.
- Provide frequent feedback (both positive and negative) to staff.
- Ensure tasks are delegated to staff with the appropriate education, training, and experience to perform the task.