The Risk Solutions Magazine **Winter 2015** UMIA

Brink

WHAT'S NEXT IN PATIENT SAFETY

ON TRIAL

Get through a malpractice suit without losing your love for medicine

One of our core values is to listen to and be inspired by our employees, customers and partners.

Dr. Rachel Remen* takes it a step further when she describes listening as an act of love. And several years ago, when Dan Rather asked Mother Teresa about her own prayers and what she says when she prays, her answer was, "I listen." Rather followed up with, "What does God say to you?" Her answer was, "He listens also."

Physicians clearly understand the value of listening to their patients in order to make a proper diagnosis, yet that process is becoming ever more challenging. The increasing patient volume and compressed time physicians can spend with their patients clearly have the potential to impact care. Add to that the fracturing relationships between physicians and their patients due to constant changes in health plans and evolving expectations, and the risk is that stress will increase for everyone.

Of all the things we hear from our customers, increasing stress, frustration and anxiety are the most concerning. Whether the stress is from an increased workload, a reduced reimbursement, an uncertain future, a frustration with technology, or myriad other reasons, it is real, and it is increasing. Just a simple search in preparing for this letter produced hundreds of articles on the topic of physician stress.

We are not here today to tell you something you already know. We want you to know that we hear you and are here to help. The intention of this edition of *Brink* is not to create awareness of increasing stress in your lives but rather to provide resources and tools to help you manage that stress. We are committed to standing with you and helping you provide outstanding care to your patients. We also hope we can help you to identify ways to bring more balance to your lives.

Thank you for the opportunity to serve you. It is our honor and privilege.

Sincerely,
Bill McDonough, President and CEO, MMIC and UMIA

WE'RE MOVING UP!
As of February 1, the UMIA office will have a new suite number. Same street address — we're just moving up a floor to suite 600. Please use the following address:

UMIA
310 EAST 4500 SOUTH, SUITE 600
SALT LAKE CITY, UTAH 84107-3993

*Rachel Remen is the author of *Kitchen Table Wisdom* and *My Grandfather's Blessings*. She is a Clinical Professor of Family and Community Medicine at UCSF School of Medicine and Founder and Director of the Institute for the Study of Health and Illness at Commonweal. www.rachelremen.com

UMIA

Brink is published four times a year by MMIC, the parent company of UMIA. Headquartered in Minneapolis, Minn., MMIC is the largest policyholder-owned medical liability insurance company in the Midwest. UMIA joined MMIC in 2013, and now serves the entire health care community, including large hospitals and health care systems, physician practices, and outpatient and long-term care facilities. By improving patient safety and physician well-being, offering risk financing and reducing risks associated with information technology, UMIA provides peace of mind so clients can focus on delivering health care.

To contact the editor, please send an email to Jane.Rodriguez@MMICgroup.com.

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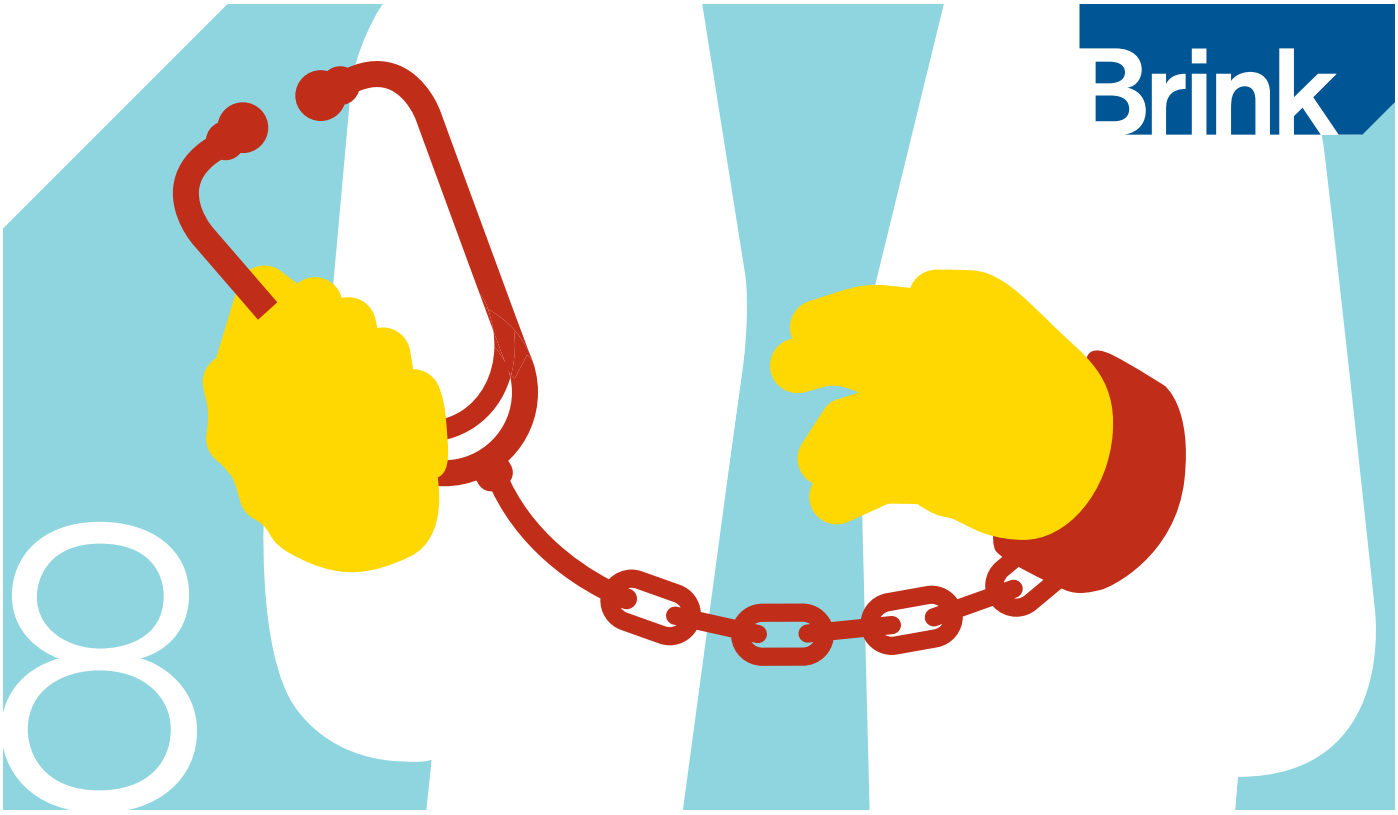
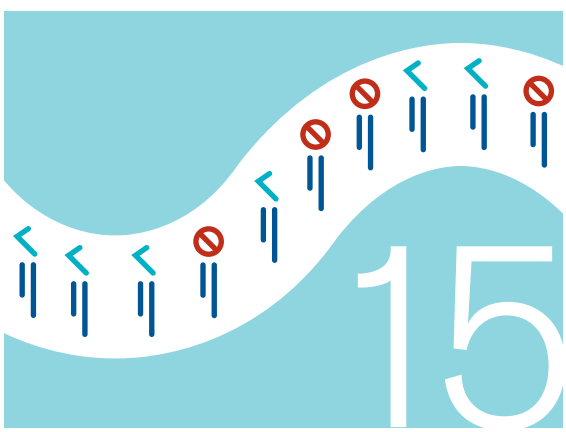
Brink





DEPARTMENTS

WINTER
2015

New+ Notable

NEW SOLUTIONS INTRODUCED BY MMIC/UMIA

TOOLS FOR TACKLING DIAGNOSTIC UNCERTAINTY

Failures in diagnosis are among the most frequent allegations in malpractice claims. Errors in diagnosis also result in higher health care costs and negative patient experiences with the health care system. We are pleased to recommend two clinical decision support tools that can help clinicians improve diagnostic accuracy and find the correct diagnosis earlier. MMIC and UMIA clients who purchase these tools through us receive a 20 percent discount.

Isabel

Isabel is a diagnosis checklist tool to help clinicians broaden their differential diagnosis and recognize a disease at the point of care. The web-based tool, which can be accessed directly or fully integrated with an EHR system, uses a patient's demographics and clinical features to produce a list of possible diagnoses, including time-sensitive "don't-miss" diagnoses.

Each diagnosis is linked to online clinical content, including textbooks, journals, abstracts and other resources. Isabel can be customized to incorporate an institution's own web resources, guidelines and protocols. The result is a unique and practical knowledge base that enables clinicians at all levels to develop and hone their clinical and diagnostic skills.

IMPROVE PERFORMANCE

Physicians who use Isabel attest that it helps improve critical thinking skills, diagnostic decision-making and referral management. When a diagnosis is correctly determined the first time, treatments are most effective, referrals are more appropriate or not needed, ordered tests are more relevant, and waste (unnecessary resource utilization and costs) is eliminated from the system. As health care moves to managing the care of populations through Accountable Care Organizations, speed to correct diagnosis is a fundamental driver of financial and clinical performance.

VisualDx

VisualDx is a diagnostic clinical decision support system that leverages the innate human ability to recognize visual patterns to assist health care providers in making faster, more accurate diagnoses. VisualDx combines high-quality, peer-reviewed medical images and concise, actionable information to support physicians in the accurate recognition and management of disease. Health care professionals can input visual clues, symptoms and patient history to help make the correct diagnosis and avoid costly and dangerous errors at the point of care.

REDUCE DIAGNOSTIC ERRORS AND IMPROVE PATIENT OUTCOMES

Between 10 and 20 percent of all diagnoses are inaccurate[1] and may result in patient dissatisfaction, harm, or serious injury including death. Physicians and patients know that proper patient management and therapy depend on diagnostic accuracy. Moreover, diagnostic error often involves common clinical scenarios and is not limited to rare diagnoses or unusual presentations. VisualDx is proven to reduce diagnostic error.

It can be especially helpful in diagnosing drug reactions early and accurately. The skin and mucosae are often the first sites of an adverse reaction, including life-threatening disease reactions. An essential safety tool for recognizing drug-induced conditions, VisualDx links to evidence-based literature documenting drug-disease associations.

1. Berner ES, Graber ML. Overconfidence as a cause of diagnostic error in medicine. *Am J Med.* 2008;121(5 Suppl):S2-S23..

MMIC AND UMIA CLIENTS ARE ELIGIBLE FOR A SPECIAL DISCOUNT ON ISABEL AND VISUALDX PRODUCTS AND SERVICES WHEN REFERRED BY YOUR MMIC OR UMIA ACCOUNT EXECUTIVE.

LYNN WELCH

COVERAGE FOR ACCOUNTABLE CARE ORGANIZATIONS

Thanks to a partnership with NAS Insurance, an independent underwriter of specialty insurance, we now offer a professional liability product that meets the unique risks of Accountable Care Organizations (ACOs).

ACO Solutions bundles leading professional liability programs as one comprehensive product including E&O, D&O, EPL, e-MD™ Cyber Liability and MedDefense.™ The product helps mitigate the unique challenges facing all ACOs, including:

- Negotiating contracts
- Defending antitrust claims
- Resolving billing errors and improper billing
- Ensuring that all providers are compliant with policies and procedures
- Coordinating the overall care of the patient population
- Protecting patient information

ACO Solutions is available for organizations where MMIC or UMIA is the medical malpractice insurer for the majority of the physicians or the facility, such as physician-owned rural health clinic ACOs, federally qualified health-center-related ACOs and critical access hospital-related ACOs.

With the addition of the new ACO product, we now have a full service offering of medical liability products and services to meet the continuously changing needs of health care organizations.

YOU CAN LEARN MORE ABOUT ACOS AND ACO SOLUTIONS AT MMICGROUP.COM > INSURANCE.

SUE LUNDQUIST

DATA LOSS PREVENTION

We understand it's imperative for your patients and their data to be protected 24/7 by a practice that's always up and running.

To ensure this protection, Health IT now offers a new data backup and business continuity solution to meet the health care risks associated with data loss and interruptions in care delivery.

We partnered with Axcient to offer a new type of cloud platform that eliminates data loss, keeps applications up and running, and makes sure that IT infrastructure never goes down. By mirroring an entire business in the cloud (storing data securely off-site), Axcient makes it simple to access and restore data from any device, to build failover IT systems, and to virtualize an entire office with a click.

LEARN MORE ABOUT AXCIENT AND ALL OF OUR HEALTH IT SERVICES AT MMICGROUP.COM/HEALTH-IT/REMOTE-BACK-UP OR CONTACT US BY PHONE AT 877.838.6869 OR BY EMAIL AT INFO@MMICHEALTHIT.COM.

MIKE MILLER

SUPPORT FOR STRUGGLING PHYSICIANS

Practicing medicine is stressful. To ensure that our clients and their physicians get the support they need — which may extend well beyond the litigation process — we have partnered with Physician Wellness Services (PWS), a company that helps physicians manage day-to-day stress and work and life issues. This service can also help health care organizations manage behavioral, psychological and other performance-related issues before they become major problems.

PWS coaches have helped their physician clients with many challenges, including:

- Unusual levels of stress
- Grief and loss in their personal lives or as a result of an adverse outcome
- Stress and anxiety that accompany a lawsuit
- Increased frustration or anger at work
- Challenges in managing administrative or other practice-related tasks
- Communication difficulties with other staff members or administration
- Relationship issues at work and in their personal lives
- Difficulty balancing the demands of family and practicing medicine

Services are provided by physician peer coaches or senior consultants who are masters- or doctorate-level behavioral health professionals experienced in working with physicians.

This fee-based program, which can be initiated by any MMIC- or UMIA-insured physician, or by an administrator acting on the physician's behalf, offers safe, confidential resources and support from someone who can empathize with, validate and normalize the challenged physician's experiences.

FOR MORE INFORMATION OR TO MAKE A REFERRAL, PLEASE CONTACT PHYSICIAN WELLNESS SERVICES AT 888.892.3861 OR VISIT PHYSICIANWELLNESSSERVICES.COM

LYNN WELCH

N+N

COMPILED BY JANE RODRIGUEZ, M.A.
Communications Director
MMIC, UMIA and Constellation
Jane.Rodriguez@MMICgroup.com

Calendar

WEBINARS ON WEDNESDAYS

To register for a webinar, visit:
MMICgroup.com/resources/webinars.
All webinars are presented from noon–1 p.m. CST and are available on demand at MMICgroup.com after the initial presentation.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Minnesota Medical Association and MMIC. The Minnesota Medical Association (MMA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The Minnesota Medical Association designates each live webinar for a maximum of one AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Minnesota Medical Association

JANUARY
14

DIAGNOSIS ERROR AND THE CHANGING HEALTH CARE ENVIRONMENT

Presenters: Donald H. Bauman, Jr. & Laurie Drill-Mellum, MD, MPH

This webinar will review the current data on diagnosis errors and the impact they have on health care. We will review the types and prevalence of diagnosis errors, identify the leading causes of diagnosis error and discuss one of the many recognized solutions to address it — clinical decision support tools.

JANUARY
28

THE CASE FOR EMPATHY TRAINING IN HEALTH CARE

Presenter: Helen Riess, MD

This webinar will provide evidence of the need for empathy and compassion training in health care. We will explore the current health care climate in terms of patient needs and provider challenges. Dr. Riess, Chief Scientific Officer of Empathetics, will demonstrate how improved patient-centered care and provider wellness is tied to providing more compassionate care while increasing the meaningfulness and joy that health care providers find in their work. This webinar will discuss the importance of empathy training for health care professionals but will not provide actual empathy training.

SPECIAL WEBINAR SERIES

STRESS & BURNOUT: HEALTH CARE IN CRISIS

PRESENTED BY MMIC PHYSICIAN WELLNESS SERVICES

FEBRUARY
4

STRESS & BURNOUT: THE CRISIS CONTINUES — RESULTS OF THE 2014 NATIONAL SURVEY

Presenter:
Deb Wood
Senior Consultant
Physician Wellness Services

MARCH
4

MANAGING STRESS AND BURNOUT, BUILDING RESILIENCY

Presenter:
Mike Drummond, MD
Physician Wellness Services Consultant

APRIL
8

DISRUPTIVE BEHAVIOR

Presenter:
Alan Rosenstein, MD, MBA
Physician Wellness Services Consultant

UPCOMING EVENTS

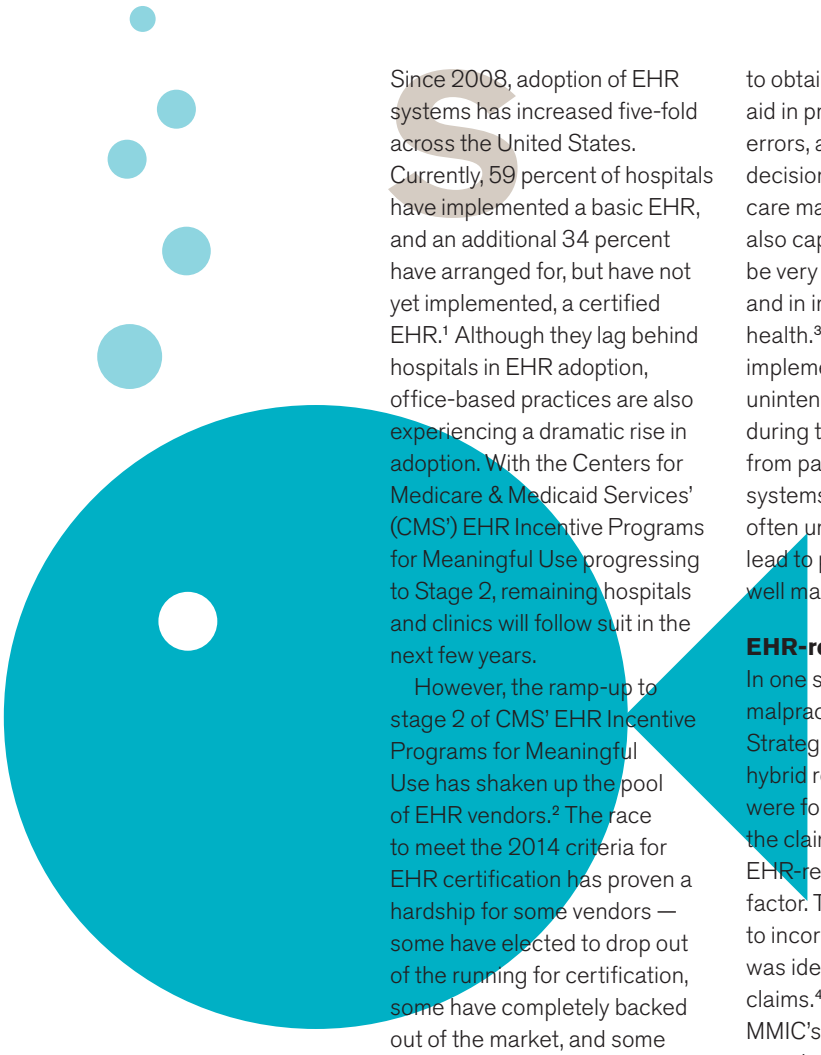
Please check the MMIC and UMIA websites for a listing of educational events scheduled for the coming months.

MMICgroup.com

UMIA.com

NEITHER FISH NOR FOWL

Beware the risks of the hybrid record.



by Trish Lugtu

Since 2008, adoption of EHR systems has increased five-fold across the United States. Currently, 59 percent of hospitals have implemented a basic EHR, and an additional 34 percent have arranged for, but have not yet implemented, a certified EHR.[1] Although they lag behind hospitals in EHR adoption, office-based practices are also experiencing a dramatic rise in adoption. With the Centers for Medicare & Medicaid Services' (CMS') EHR Incentive Programs for Meaningful Use progressing to Stage 2, remaining hospitals and clinics will follow suit in the next few years.

However, the ramp-up to stage 2 of CMS' EHR Incentive Programs for Meaningful Use has shaken up the pool of EHR vendors.[2] The race to meet the 2014 criteria for EHR certification has proven a hardship for some vendors — some have elected to drop out of the running for certification, some have completely backed out of the market, and some have providers questioning their systems' viability. As a result, a growing number of organizations will also be adding legacy EHR data to their pool of hybrid records.

It is hard to argue against the benefits of EHRs, such as their use in reminding patients to obtain preventive care, their aid in preventing medication errors, and their role in clinical decision support for chronic care management. EHRs also capture data that can be very helpful in research and in improving population health.[3] But the wave of rapid implementation has had an unintended consequence: during the transition period from paper to electronic systems, hybrid records are often unavoidable and can lead to patient harm if not well managed.

EHR-related claims

In one study of EHR-related malpractice claims by CRICO Strategies, problems with hybrid records and conversions were found in 16 percent of the claims with at least one EHR-related contributing factor. This was second only to incorrect information, which was identified in 20 percent of claims.[4] A further analysis of MMIC's claims from 2010–2012 revealed, however, that only 1.1 percent of all claims involved an EHR-related contributing factor.

Although such a small percentage might not seem significant, consider the number of years it can take for an incident to become a claim. In EHR-related claims analyzed from 2010–2012, EHR-related incidents occurred as early as 2007 — that is, three years prior to the claim! Given this time lag, it is reasonable to predict an increase in EHR-related claims in coming years — especially since all health care organizations switching from paper to electronic records will, at some point, be working with a hybrid record.

Hybrid record pitfalls

Hybrid record issues and conversion problems can occur any time disparate systems are maintained — not just during implementation. Additionally, hybrid records are not created solely by mixing paper and electronic records; they also can proliferate in nonintegrated electronic systems, such as a system that uses a practice management system (PMS), a lab information system (LIS), a picture archiving and communication system (PACS), or even a legacy EHR. Operating with disparate systems can cause hybrid records to persist indefinitely.

Other sources of information can also contribute to the creation of hybrid records, including transcribed documents, faxed documents, X-ray films and other media.

How to minimize the risks of hybrid records

KNOW WHERE AND WHEN TO LOOK FOR INFORMATION.
When EHR modules are rolled out over time, medical records become moving targets. And no formula for a "go live" strategy fits all practices. Some practices bring their EHR online by location, others by groupings of physicians according to specialty or even technical aptitude, still others with a combination of these approaches. During these various transitions, it is crucial to know where to look for different types of information.

A helpful tool to mitigate transition risk is a simple and easily accessible tracking system, such as a spreadsheet, that documents the shifts of information. At the very least, this tool should list the record type (e.g., lab, X-ray), the system (e.g., film, CD-ROM, EHR, PACS, LIS), and the timeframe. If groups of providers transition at different times, this information should be noted as well. This becomes especially important when a provider sees a patient on behalf of a colleague. A useful example of a tracking tool can be found in the American Health Information Management Association's guide for the legal record.[5]

NOTIFICATION OF CRITICAL INFORMATION IS CRUCIAL.
In an EHR environment, incoming documents can easily be missed if notifications are not implemented. Make sure EHR staff understands the importance of filing and tasking test and lab results accurately, no matter where those results originate — from electronic interfaces with external organizations or from manually scanned or filed documents. Help staff to define the different levels of notifications for critical and noncritical results.

LEVERAGE AUDITING REPORTS TO LOOK FOR OPEN ORDERS.
EHRs must be implemented to leverage the ability to audit open orders. Work with your EHR staff to identify all the modes for ordering tests, so staff is empowered to create appropriate audit reports.

To minimize issues with hybrid records, physicians must stay engaged throughout the EHR implementation process — to identify gaps in information during patient care, to define critical thresholds for notification, and to empower EHR support staff to create appropriate audit processes.

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2. Bresnick J. Replacing your EHR in light of Stage 2 Meaningful Use. EHR Intelligence. http://ehrintelligence.com/2014/04/15/replacing-your-ehr-in-light-of-stage-2-meaningful-use/. Published April 15, 2014. Accessed October 19, 2014.

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4. Ruder D. Malpractice Claims Analysis Confirms Risks in EHRs. *PSQH.* 2014;11(1):20-23.

5. American Health Information Management Association. Managing the Transition from Paper to EHRs. http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_048418.hcsp?dDocName=bok1_048418. Updated November 2010. Accessed October 6, 2014.

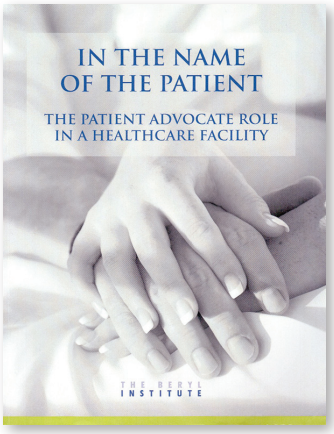
TRISH LUGTU, BS, CPHIMS, CHP
R&D Manager, Health Informatics
Patient Safety Solutions, MMIC
Trish.Lugtu@MMICgroup.com

THROUGH A PATIENT'S EYES

One of the greatest gifts we can give to our patients is the balance between consistently providing superior clinical performance and generating purposeful interactions that bring meaning and healing to the patient and to family members. To thrive, and even to survive, health care organizations need to provide the kind of experiences that create a lasting emotional connection with patients. This connection — this customer engagement — is the key to developing relationships that are enduring and profitable.

Patients are consumers. They exchange money for services, and they want the best value they can get for their money. Yet health care is so much more than a financial transaction; it's also a highly emotional experience because customers are usually sick or injured and under considerable stress. When health care organizations provide high-quality care and strive to create a positive patient experience, they create a form of engagement that is optimal for the patient, the providers and the organization's bottom line.

The concept of patient experience is evolving into a discipline that focuses on delivering value from the patient's perspective. It's a complex puzzle integrating all facets of care from clinical quality and safety to communication and organizational culture.



In the Name of the Patient, a comprehensive guidebook developed by the Beryl Institute, provides an array of templates, case studies and tools to help health care leaders continuously improve the patient experience. The guide touches on an array of topics such as:

- Designing patient advocacy programs: philosophy, policies, roles and job descriptions
- Managing complaints, service recovery, mediation and conflict negotiation
- Providing patient- and family-centered care and understanding patient's rights
- Evaluating the patient experience and creating a culture of service excellence
- Achieving compliance with legal and regulatory standards

The Beryl Institute's mission is to establish and provide leadership for a global community of practitioners invested in improving the patient experience. This fifth edition of *In the Name of the Patient* has been updated with new information, which will be useful for all medical staff and medical support staff who work with patients.

LISA FAY, MBA
Sr. Strategic Marketing Director
MMIC and UMIA
Lisa.Fay@MMICgroup.com

"PATIENT EXPERIENCE AND SATISFACTION IS THE NO. 1 PRIORITY FOR HEALTH CARE EXECUTIVES, ACCORDING TO THE HEALTHLEADERS MEDIA SURVEY 2013 — ABOVE CLINICAL QUALITY, COST REDUCTION, AND MANY OTHER BURNING ISSUES. YET THERE IS LITTLE CONSENSUS ABOUT HOW TO MEASURE, IMPROVE, AND INCORPORATE PATIENT EXPERIENCE INTO HOSPITAL PROCESSES."

– JACQUELINE FELLOWS, HEALTHLEADERS MEDIA, AUGUST 13, 2013

ON

Get through a malpractice suit without losing your love for medicine.

by Ronald L. Hofeldt

TRIAL

According to the American Medical Association, 42 percent of physicians will face a medical liability claim at some point during their career.[1] Working through the litigation process is one of the most difficult things a physician will ever go through on both a legal and personal level. A study published in the *Western Journal of Medicine* in 1988 found that 70 to 86 percent of surveyed physicians reported feeling tension, depression, frustration and anger while going through litigation. In addition, during the period of litigation, a number of them were diagnosed with a new physical illness or experienced the exacerbation of an existing one, such as hypertension or coronary artery disease.[2]

A malpractice suit is often a shocking and unexpected event. Physicians who are sued often perceive themselves as having failed. That perception erodes their self-esteem and their confidence in their ability to practice medicine.

Because a typical malpractice claim takes an average of two years to resolve, it can have a dramatic effect on a physician's practice. Far too often physicians lose the feeling of joy that they get from practicing medicine; some may even leave the profession during the prime of their careers. In an attempt to lessen the risk of further exposure, physicians who are going through litigation often limit their practice by refusing to treat high-risk patients or perform high-risk procedures. In addition, they are often at risk for a range of health concerns brought on by exposure to chronic stress including myocardial infarction, cancer, hypertension, anxiety, depression, abuse of alcohol and other drugs, accident-related injuries and even suicide. Because of the added strain, physicians' personal relationships can suffer, and anecdotal evidence of an increase in marital discord and divorce has been noted.

Physicians who've been sued worry about the five Rs: reputation, referrals, recredentialing, reinsurability and remuneration.[3] Yet, even though they have reason to be concerned about these issues, very rarely do they become problematic in the event of a single lawsuit. However, because their medical training fails to educate them about the likelihood of being sued and the emotional toll that it will take, physicians often feel shame and humiliation when they are sued. This often causes them to withdraw from social and professional activities; they avoid colleagues in the hospital, arrive late to meetings, and leave early. This creates a harmful cycle, as hiding in silence only further erodes their confidence and self-esteem.

More than legal aid

A number of groups have recognized that physicians need more than legal support when facing a lawsuit, and some have created resources that allow physicians to share their feelings, acknowledge their fears, and address the emotional impact of litigation. The Physician Litigation Stress Resource Center (www.physicianlitigationstress.org), for example, is a nonprofit organization that directs practitioners to articles, books and websites that offer strategies for coping with the stress of litigation. In addition, a number of medical malpractice insurance carriers offer physicians help in dealing with the stress and emotions associated with litigation.

MMIC created the Physician Litigation Support Program in 2008 after findings from a survey of physicians indicated that lawsuits deeply affect those involved in a malpractice suit and highlighted the lack of resources for them. Defense attorneys have also reported that cases that were highly defensible were too often settled, sometimes for large sums of money, because physicians were unable to withstand the pressures of litigation and the rigors of trial. We decided to take a proactive approach and developed a litigation support program for our clients.

When a claim or lawsuit is brought, physicians automatically receive a letter introducing the program. By taking advantage of these services, physicians have an opportunity to share their feelings with a colleague who is knowledgeable about the litigation process and has skills in litigation coaching. Most clinicians are greatly relieved to have an opportunity to openly discuss their feelings about the suit. They've often been carrying the load alone and are grateful to be able to confide in a fellow physician who understands their

feelings and is nonjudgmental. In addition to being able to discuss what they are feeling and how those feelings are affecting them, physicians who take advantage of the program receive the following assistance, which can help them feel more empowered:

EDUCATION ABOUT THE LITIGATION PROCESS

Litigation is often an unfamiliar and intimidating process. Physicians need to know what to expect and how to prepare for the grueling ordeal that lies ahead. For that reason, it is essential that physicians are knowledgeable about every aspect of the litigation process. The more they understand, the better they perform in the courtroom.

HELP WITH PREPARATION

Before testifying at their deposition or trial, a physician is coached on how to be a credible and persuasive witness. Because the deposition and trial provide an opportunity for the plaintiff's attorney to intimidate or discredit the physician, the physician must be well prepared and skilled in maintaining control over his or her testimony. Physicians often are too helpful during the deposition, which is a common mistake. The less information the physician volunteers, the better.

Testifying is an emotionally charged experience, and how the physician deals with the situation is central to how a suit eventually turns out. If the physician reacts negatively while in the witness chair, the outcome can be altered, and sometimes a case is settled that would otherwise be defensible. For that reason, the physician needs to learn about the attacks and the tricks that often come from the prosecuting attorney and also needs to understand that comments should not be taken personally. With preparation and support, physicians will feel less fear and uncertainty and be more resilient when questioned by attorneys.

REFERRAL TO LOCAL RESOURCES

When physicians need professional or psychiatric assistance, local resources are sought and appropriate referrals made. On occasion, physicians may be advised to promptly contact their primary care physician for assessment and treatment of underlying depression, anxiety or other conditions. Appropriate follow-through ensures that necessary care is provided.

EDUCATION ABOUT THE IMPORTANCE OF SELF-CARE AND SELF-AWARENESS

Physicians who are going through litigation are encouraged to follow the advice they give their patients: to slow down, eat right, socialize, exercise, meditate, discover outside interests, play, laugh and have fun. They are also encouraged to clarify their personal and professional values and goals. Are they practicing the way they want? Do they need a better work-life balance? Even though litigation is painful, it can help physicians refocus and define for themselves what in life is meaningful and fulfilling. Over the years, many physicians have shared that a malpractice suit helped them slow down and taught them to "take time to smell the roses."

HELP WITH MOVING ON

Once the case is over, physicians experience a huge sense of relief. But it takes time to put the experience in perspective. Physicians who have been through the process and received help through the Physician Litigation Support Program understand that litigation is an inevitable part of practicing medicine. As a result, they can look at their work with new insight. For example, they might better appreciate the importance of documentation and informed consent — elements of medical practice that are sometimes forgotten. And they might understand better the importance of keeping an open channel of communication with patients and their family members, as well as with co-workers, in order to lessen the chance of misunderstandings. In addition, they may be more empathetic to colleagues who are going through the process.

They also learn to step back and remind themselves of their extraordinary talents and skills as healers who care deeply about their patients. Instead of focusing on the one patient who brought the lawsuit, they can learn to think instead about the good they do for all of their patients and the wonderful gifts they give them daily.

Conclusion

Litigation is a complex and demanding ordeal. Physicians who go through it often report that having someone who can help them gain in-depth knowledge and understanding of the process and who can offer them support along the way significantly lessens its toll on both their professional and personal lives. A physician who recently went through a prolonged trial that ended with a successful defense verdict stated, "I never want to go through this again. But if I do, take my hand and guide me through it. Reducing the uncertainty about the litigation process made a huge difference."

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RONALD L. HOFELDT, MD
Physician Litigation Support, MMIC and UMIA
Ronald.Hofeldt@MMICgroup.com

HEALTH CARE HURDLES

Improving care by overcoming the barriers between doctors and patients.

Providers today face unique barriers to the care of patients. Managed care adds layers of administrative work that can take time away from patient care. Technology adds another potential layer of interference in the physician-patient relationship. Decreasing reimbursements often lead providers to see more patients per day, further decreasing the time spent on each encounter. Finally, changes in reimbursement methods and financial pressures often lead physicians to become employed by hospital corporations, which can add yet another layer between physician and patient.

Chaos

Medicine has always been chaotic with many unknowns. You can schedule a day of patient visits but cannot prepare for unexpected phone calls or emergencies or for unanticipated complications that emerge during a visit. However, you can control the timing of appointments and leave spaces to accommodate the unexpected. This simple precaution can relieve pressure and improve your job satisfaction.

A morning huddle to review the schedule for the day with your assistant and to prepare for potential problems also helps to avoid chaos. A little foresight can help make your day easier, whether it's planning for patients who need more time, obtaining results of tests, finding summaries from an ER visit or hospital stay, or identifying a patient that might need another reminder to arrive on time.

Technology

Technology can improve patient care if it adds to patient safety. Technology can interfere with the physician-patient relationship if the provider faces the computer more than the patient. A few minutes in the exam room face to face with the patient without the computer can improve patient engagement and satisfaction. Likewise, the patient experience and the physician-patient relationship can be improved by explaining to the patient what information is being entered into the computer or turning the screen so the patient can see what is being done.

Financial pressures

When a provider searches for ways to increase revenue, the priority should always remain patient safety. Adding more patients to the schedule often decreases time per visit, which can impact patient satisfaction. More patients in a given day with decreased time per patient can lead to more opportunities for errors, both diagnostic errors and missed results.

Employment by a hospital corporation can eliminate provider autonomy. This can impact the physician-patient relationship as processes may change in a clinic owned by a large corporation as compared to the provider's former patient care in private practice.

Overcoming barriers

Providers can counteract some of these effects by increasing patient engagement. Engaged patients will call for their results and be sure that their results do not fall through the cracks. Engaged patients will be willing to ask questions about when to return if a treatment is not effective or if the response is not as predicted, and therefore the provider will have an opportunity to reassess the patient and avoid diagnostic errors.

Physicians enter medicine to care for patients. In the current challenging health care environment, a few safeguards can be put in place to improve patient safety and also enhance the physician-patient relationship. An improved physician-patient relationship can increase both provider and patient satisfaction.

PATRICE F. HIRNING, MD, MACP, CPHRM

IS YOUR EHR A HELP HEADACHE?

Most doctors say a little of both.

by Trish Lugtu

Ask any physician about EHR systems and you will get a profusion of contradictory responses — EHRs improve quality of care; EHRs hinder patient care; EHRs speed access to patient information; EHRs lack complete information; EHRs provide too much information. Yet, a solid four out of five physicians surveyed wouldn't go back to paper.[1]

While EHRs are still in their early stages of maturity, four out of five physicians' acceptance seems like a pretty positive outlook. Physicians generally approve of EHRs in concept, but the reality is that EHRs have both positive and negative effects on physicians' professional satisfaction, and sustainable relief from health-information-induced stress won't arrive without considerable coordination.

EHRs impact physicians' professional satisfaction

In a recent study by the RAND Corporation, which queried 30 physician practices across six states to understand how health reform is impacting professional satisfaction, an unanticipated theme regarding EHRs arose so strongly that researchers revised their surveys to elicit further feedback from physicians. The study identifies the top five contributors to physicians' professional satisfaction, and EHRs make a significant impact on several of them.[1]

- Perceived ability to deliver high-quality patient care
- Reasonable control over the environment, pace and content of work
- Sharing clinical values with organizational leadership
- Respectful professional relationships
- Incomes perceived as predictable and fair

On the positive side, EHRs hold great promise

There is a strong correlation between physicians' professional satisfaction and the ability to deliver quality care. Physicians believe clearly in the promise of EHRs to enable improvements to quality care. Physicians appreciate the ability to access patient information remotely and are experiencing positive functionality in EHR systems, such as being able to see trends in health indicators over time. Enhanced messaging between providers on the same system was also identified as a significant factor for improving the delivery of quality care. Overall, physicians are optimistic about the future of EHRs. But EHRs in their current state still have a long road ahead before they can meet physicians' expectations.

OR A

A little planning goes a long way

The first HIT-induced stressor that bears mentioning is that the regulatory and financial burdens of implementing health information technology take their toll. In many cases, implementing EHRs has proven to be more expensive than anticipated for some practices, which threatens practice financial sustainability, and the efforts to comply with Meaningful Use and HIPAA regulations have been underestimated.

In many cases where practices struggle, best practices are commonly found lacking during the evaluation and implementation process. Investing up front in trusted and experienced resources to help evaluate systems, design infrastructure and manage implementation projects will help establish efficiencies and save costs in the long run.[2]

Another way to share the regulatory workload is to bring in trusted outside resources to leverage managed services, such as managed security compliance services or managed IT services. For a fraction of a full-time equivalent, the full functionality of those service providers can build a solid foundation of ongoing IT maintenance.

Poor EHR usability and degradation of clinical documentation

A second HIT-induced stressor is the ongoing struggle to balance EHR work flows with clinical work flows. Physicians aren't developers, developers aren't designers, and designers aren't physicians, yet it takes all three of these skills to make successful and usable EHR templates.

This may be one of the toughest stressors because the standardization of safer and more usable EHRs must happen at a federal level, such as through the Food and Drug Administration Safety and Information Act Health IT Report and its call for a national Health IT Safety Center,[3] as well as the Office of the National Coordinator for Health Information Technology's (ONC's) recently outlined 10-year vision to improve interoperability.[4] Physician associations have also articulated their stances in order to support the call for improvements. The American Medical Informatics Association published a list of recommendations to improve EHR usability from a patient safety standpoint,[5] and shortly thereafter the American Medical Association published its priorities for EHR usability principle[6] in response to the RAND study of physician satisfaction.

Meanwhile, the best course to manage usability and documentation quality at the organizational level is to reiteratively assess templates and work flow and make improvements incrementally. Physician engagement in work-flow design is essential to improving EHR systems, and regular audits of notes generated after a patient encounter will raise awareness of the quality of the documentation produced.

Interference with face-to-face patient care

As stated by an elderly patient in a feedback questionnaire, "My doctor was playing solitaire during my checkup." As physicians become consumed by interacting with an EHR, patients may express feeling left behind. At the root of this decreasing point of patient satisfaction, as well as physician satisfaction, is the physician's inability to look into a patient's eyes during an EHR interaction.

In one study,[7] physician-EHR interaction styles — technology-centered, human-centered, and mixed — were measured for their impact on patient satisfaction. The study looked at such factors as physician demographics, how often and how long a physician

Tip:
Practice or rehearse eye contact in a patient visit simulation and ask for feedback. Becoming aware of when it is appropriate to look at the screen versus the patient, as well as positioning your computer to avoid turning completely away from a patient, is key to optimizing eye contact.

looked at an EHR, verbal cues given by the physician during EHR viewing and others.

While each style was found to be effective under different circumstances, the study highlighted a need for understanding the pros and cons of each style and for an overall formalization of training for physician-EHR interactions to minimize patient disengagement.

keyboard and to consider the use of certified scribes where appropriate.[8]

Inability to exchange health information between EHR products

The last key HIT-induced stressor, which also holds the best promise for EHRs, is caused by the inability to exchange health information between EHR systems. We've seen the success of improved care within health systems where multispecialty providers access patient information through the same EHR, but independent health care organizations lack this ability. And at times, even systems within the same organization are not able to connect.

The challenge is to get all systems, vendors and organizations on the same platform to increase connectivity but to do so without taking away the ability to innovate. Toward this end, ONC outlined a path toward interoperability in its recent vision document.[4] Unfortunately, the path toward interoperability, which will coordinate vendors, systems, and health care stakeholders alike, is on a 10-year plan.

As we watch the plan unfold, each physician or health care organization can only actively engage to connect systems singularly where appropriate and when feasible. Eventually, our national web of connectedness will grow.

Tip:
Undertake a cross-functional approach to EHR screen design to ensure that appropriate and required data are captured, while extraneous fields are eliminated or hidden.

Inefficient and unfulfilling work and time-consuming data entry

An important aspect of EHR usability is the optimization of information to reduce the cognitive load of physicians — prioritizing and displaying only the important, relevant and recent data for the task at hand. However, cross-functional review of screens is important for verifying that appropriate and required data are captured. Physicians, clinicians, Meaningful Use implementers, coders, and risk managers should at least review screens during the development process to include required fields and exclude extraneous fields.

It is important also to check the scope of practice within state statutes to verify what functions physicians are required to complete and what functions can be delegated, to assess providers for general computer skills, such as the ability to navigate the operating system, use the mouse and

Stay the course

The most important take-away from the RAND report regarding EHRs is that overall physician professional satisfaction was found to be independent of satisfaction or dissatisfaction stemming from the EHR. The significance of the RAND report's statement comes with the understanding of a shared belief that EHRs and HIT are strong in concept and are on a path of improvement toward a shared goal, regardless of their current state.

Our best way forward is to stay the course and focus on the aspects of health care that motivated us in the first place, knowing that the HIT-induced stressors will improve with time and coordinated effort. And, lastly, we can rest assured that the nation is responding, planning and acting to improve the effectiveness of EHRs.

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TRISH LUGTU, BS, CPHIMS, CHP
R&D Manager, Health Informatics
Patient Safety Solutions, MMIC
Trish.Lugtu@MMICgroup.com

SHIFTING SEAS

Implementing a compliance program to meet ever-changing regulations.

by D. Michelle Kinneer

The Office of Inspector General (OIG) has issued compliance guidance for health care entities since 1998. Over time, both the regulatory environment and the health care landscape have changed. Under the Patient Protection and Affordable Care Act of 2010, compliance programs, which were formerly voluntary, will become mandatory.[1] While we are still waiting for the Centers for Medicare & Medicaid Services' guidance on program design, it is clear that practices need to stay abreast of changes and requirements.

Compliance can be intimidating. Penalties for noncompliance can include fines, criminal penalties, and exclusion from governmental programs. When considering compliance in the individual or small practice, a good place to start is with the Compliance Program Guidance for Individual and Small Group Practices published in 2000 by the OIG.[2] The OIG also provides educational materials that help physicians navigate health care compliance.[3] This article will cover the basics of compliance in health care and provide tips on finding tools to increase the effectiveness of your program.

The pillars of compliance

Fortunately, health care compliance programs have commonalities, often referred to as pillars. These include assigning a designated compliance officer, auditing and monitoring, providing training and education, ensuring open lines of communication, responding appropriately to detected offenses, and publicizing and enforcing guidelines. The government's guidance for hospitals and other entities requires that these pillars be fully developed. Physician practices are granted a bit more leeway, as the government understands that solo and small practices often do not have the resources for a fully implemented program.

The OIG suggests two approaches for implementing a compliance program. The first is to consider those elements that would best serve your practice, identifying issues you have had in areas such as record requests or billing rejections, and implementing components that address those issues.

The second path is to approach compliance as a stepped process in which you build upon the pillars. The first step is auditing and monitoring. An audit may reveal policies that need updating to stay current with regulations. This in turn will necessitate educating and training staff on new processes that need to be implemented.

Auditing and monitoring can take various forms. A common audit is to review a sample of medical records to determine whether the documentation supports what the patient or insurance company was billed. A policy audit consists of reviewing a practice policy and then following the steps in the policy to determine if the practice is consistent with the policy. The subject matter of audits can come from external sources like State Board disciplinary actions. In Iowa, for example, several actions relate to pain management. If your office provides pain management, reviewing those actions can help you audit your own practices in that area.

ORGANIZATIONS THAT EMPLOY OR CONTRACT WITH AN EXCLUDED INDIVIDUAL CAN BE FINED $10,000 FOR EACH SERVICE OR ITEM THEY PROVIDE, ALONG WITH DAMAGES UP TO THREE TIMES THE AMOUNT CLAIMED.

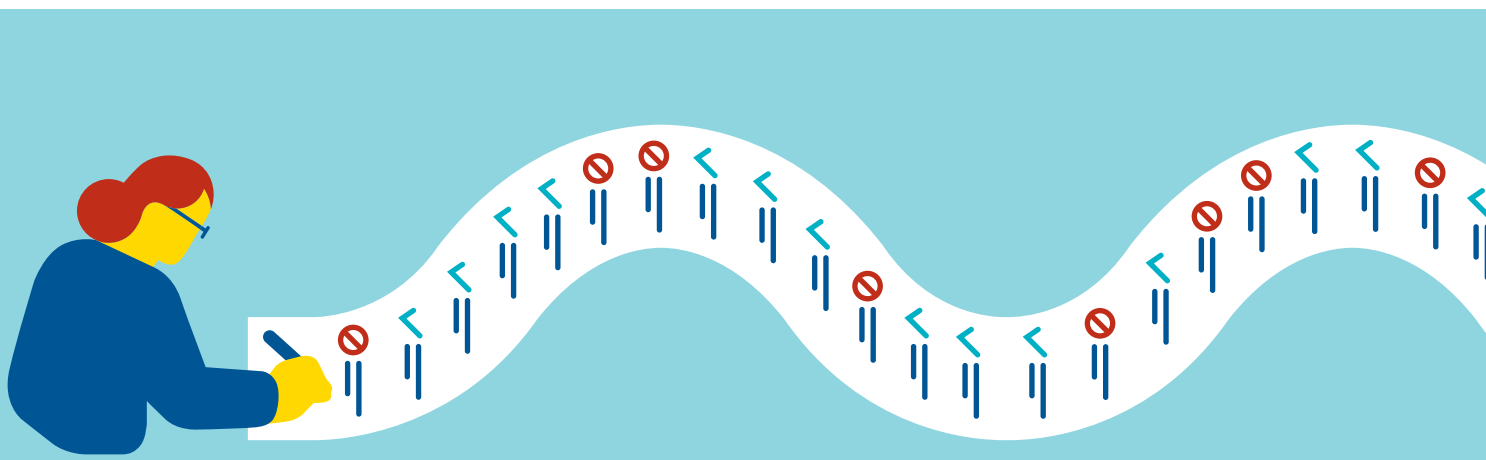
Corporate integrity agreements

When a practitioner or an organization runs afoul of regulations, they can enter into a corporate integrity agreement (CIA) to avoid exclusion from governmental programs. CIAs are available to the public on the OIG website.[4] As you review such agreements, look for practices similar to yours and review the requirements those practices agreed to implement. For the most part, these will include the pillars of an effective compliance program. Other compliance measures often found in these agreements include reporting obligations and ensuring that hiring practices include checking exclusion status.

As an example of how to use CIAs, I reviewed one for a solo practitioner that was entered in 2014. If I were a solo practitioner, I would consider ways to implement the requirements specified in that agreement in my own organization. For instance, I could set up the recommended training. I could use the audit requirements as a road map for my auditing program. In this way, CIAs can aid in establishing a compliance program or evaluating your current program's effectiveness.

The exclusion penalty

Make sure you understand the exclusion penalty. Payments are prohibited for items or services provided by or under the prescription of an excluded individual. Organizations that employ or contract with an excluded individual can be fined $10,000 for each service or item they provide, along with damages up to three times the amount claimed.[5]



To ensure the eligibility of persons employed by health care programs, the OIG directs organizations to consult a List of Excluded Individuals and Entities (LEIE) prior to hiring and periodically thereafter. The list, located on the OIG website,[6] is updated monthly and is easy to use by simply searching a person's name. If your practice accepts Medicaid payments, you should also check your state's exclusion list. A second federal database for exclusions is the System of Award Management (SAM).[7] The OIG encourages the use of the LEIE as your primary source and of SAM as a possible source. It is also good practice to include, in your organization's contracts and agreements, a clause requiring other parties to inform you if they lose their eligibility.

The benefits of professional societies

Another important tool for a compliance program is to stay involved with professional societies. These organizations often highlight important steps you can take to maintain your program. For instance, the American Medical Association has educated its members about the Sunshine Act for several years, providing a toolkit physicians can use to enroll and to verify data.[8,9,10] Have you as a provider registered and taken steps to ensure the accuracy of the information tied to your name?

Professional organizations do more than provide members with education on compliance. They provide advocacy and suggest methods of implementing regulations that are feasible for their members. Staying active in a professional organization can help you understand the steps you must follow to comply with new regulations.

Compliance, like medicine, is complex and dynamic. It is important that your compliance program be tailored to your practice. By implementing the tools discussed here, you can show your commitment to operating within governmental regulations. You can catch and correct problems in your systems that could put you in breach of the regulations. Putting resources into developing a compliance program before it is mandatory will help you to prepare for the change. We suggest that you contact an attorney familiar with health care compliance for particular questions or concerns that you may have about your compliance program.

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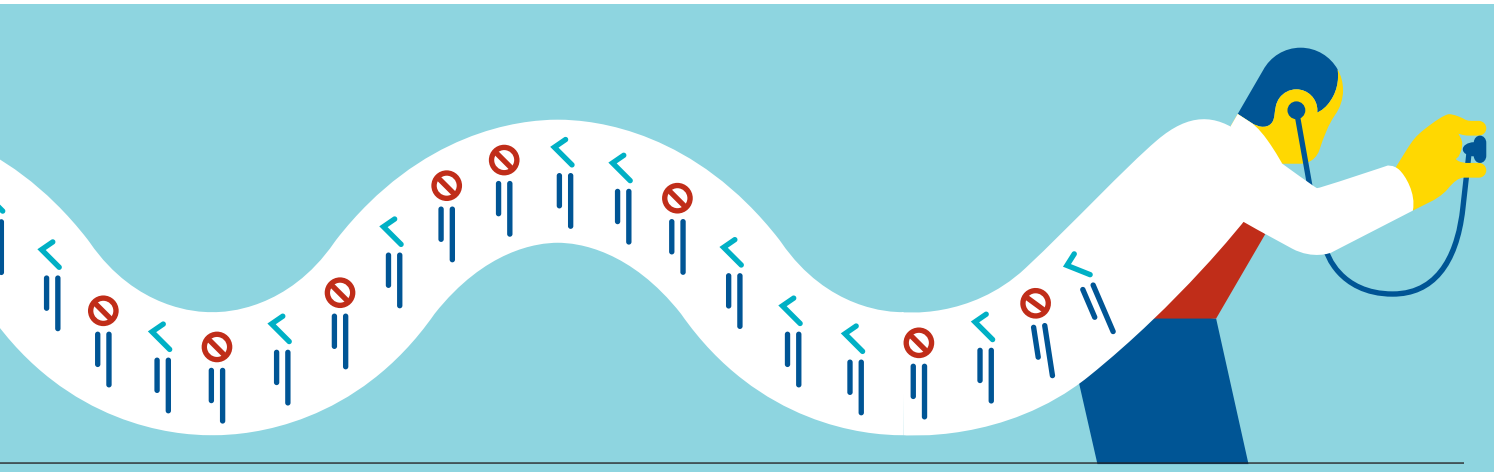
D. MICHELLE KINNEER, RN, MSN, JD, CPHRM, DON-CLTC
Senior Risk and Patient Safety Consultant, MMIC
Michelle.Kinneer@MMICgroup.com



DOUBLE TROUBLE

Nurses misread fetal heart rate patterns, and a patient in labor refuses her OB's recommendation for surgical intervention.

SPECIALTY	ALLEGATION	PATIENT SAFETY FOCUS
⁄ OB	⁄ Improper performance of electronic fetal monitoring	⁄ Electronic fetal heart monitoring ⁄ Informed consent and refusal

Facts of the case

A 36-year-old gravida 1, para 0 woman was admitted to the hospital for labor induction at 41 weeks' gestation. Prior to induction, she verbalized that she did not want regional anesthesia and voiced a strong desire to avoid any surgical intervention during delivery. The obstetrician placed Cytotec at 7:30 a.m.

At 11:30 a.m., the OB nurse noted there was spontaneous rupture of membranes and observed variable decelerations in the fetal heart rate (FHR) using electronic fetal monitoring (EFM). The nurse documented that the woman was dilated to 3 cm and was 100 percent effaced. At 12:30 p.m., the nurse noted the patient was 10 cm dilated and pushing.

At 1:30 p.m., the obstetrician examined the woman and discussed using forceps to deliver the baby due to ineffective pushing, maternal exhaustion and abnormal FHR patterns. He also recommended performing a C-section to expedite delivery. The mother declined using forceps and refused a C-section delivery. The OB nursing staff documented that the obstetrician left the bedside at 1:35 p.m. to return to his office to see patients.

A half hour later, the OB nurse questioned whether the EFM was tracking the FHR or the mother's heart rate and called the obstetrician to return to the bedside. The obstetrician examined the woman, reviewed the EFM tracings and again discussed using forceps to deliver the baby. The woman finally agreed.

The obstetrician delivered a baby boy 15 minutes later. The baby had poor fetal tone, no respiratory effort and no heartbeat. He was resuscitated and transferred to the NICU where he died during the night.

The woman filed a malpractice claim against the obstetrician, the hospital and the OB nursing staff alleging improper performance of EFM and failure to promptly deliver the baby resulting in his death.

Disposition of case

The case was settled against the obstetrician, the hospital and the OB nursing staff.

Patient safety and risk management perspective

The experts who reviewed this case could not support the OB nursing staff's care of this woman and its interpretation of the FHR patterns. They noted that an hour prior to the rupture of membranes, the woman was contracting too frequently and that when the membranes ruptured spontaneously at 11:30 a.m., the FHR pattern was abnormal. They also commented that at 12:30 p.m. when the woman began to push, the FHR pattern showed that the baby continued to decline. They stated that the OB nursing staff failed to recognize and communicate the abnormal FHR patterns to the obstetrician.

The experts also criticized the obstetrician for failing to communicate effectively with the woman about the condition of the baby, given the abnormal FHR patterns, and about the necessity for surgical delivery. The experts stated his documentation of the informed consent conversations was sparse.

The woman testified that she did not understand the seriousness of the situation or the risks to her baby by not allowing the use of forceps or the performance of the C-section. She stated that had she understood, she would have consented.

The obstetrician testified that in hindsight he should have communicated more effectively to convince the woman to proceed with surgical intervention sooner rather than later. He said that the FHR patterns were concerning for far too long.

Patient safety and risk management tips

- Use National Institute of Child Health and Human Development (NICHD) standardized FHR pattern definitions to facilitate interpretation and communication
- Provide the same EFM education and training for both providers and OB nursing staff
- Use evidence-based tools at the bedside that define and classify FHR patterns
- Use evidence-based FHR management decision algorithms to ensure standardized management of abnormal FHR patterns
- Use a clinical decision support system that provides real-time automated assessments of labor progress and FHR patterns to assist nursing staff and providers
- Understand that health literacy issues may hamper communication with patients and families; use words that patients can understand when having informed consent discussions; be specific and emphatic about the risks of not following recommended care
- Document thoroughly all informed consent discussions and all informed refusals from patients of recommended care

Electronic fetal monitoring
EFM is done during labor and delivery to monitor the FHR and the strength and duration of uterine contractions in order to assess fetal oxygenation and the progress of labor. Variable and inconsistent interpretation of FHR patterns can cause improper management of labor and delivery resulting in adverse outcomes.

The keys to safe intrapartum FHR monitoring include:

- Accurate definitions of FHR patterns
- Evidence-based interpretation of FHR patterns
- Standardized management of abnormal FHR patterns

LORI ATKINSON, RN, BSN, CPHRM
Manager, Research, Development & Education, MMIC
Lori.Atkinson@MMICgroup.com

MMIC OB Risk Solutions

Obstetrics is a high-risk specialty for patient injury and malpractice claims. MMIC OB Risk Solutions incorporates an online Electronic Fetal Monitoring (EFM) education program, webinars, tools and checklists to enhance physician and health care professional knowledge and reduce preventable injuries.

TOOLS AND CHECKLISTS

- ABCD fetal heart rate (FHR) management
- Three-tier FHR classification system
- Intrapartum FHR management decision model
- Oxytocin algorithm
- Template for operative vaginal delivery addendum
- Template for shoulder dystocia addendum
- Template of vaginal delivery

WEBINAR RECORDINGS

- Contemporary Intrapartum Fetal Heart Rate Monitoring — Applying Principles of Patient Safety featuring David A. Miller, MD, FACOG
- Evidence-based Use of Oxytocin for Labor featuring Cathy Ivory, PhD, RNC-OB, RN-BC

GENERAL ELECTRIC HEALTHCARE'S ELECTRONIC FETAL MONITORING PROGRAM

The American Congress of Obstetricians and Gynecologists, the Association of Women's Health, Obstetrics, and Neonatal Nurses, and the American College of Nurse-Midwives agree on the use of common fetal monitoring terminology, but not all clinicians are consistently trained. The General Electric Healthcare Electronic Fetal Monitoring Program promotes knowledge and use of standardized definitions to describe, interpret and communicate FHR tracings, helping to maximize safe patient outcomes and minimize risk.

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RULE OUT THE ZEBRAS

The most common diagnosis isn't always the correct one.

SPECIALTY	ALLEGATION	PATIENT SAFETY FOCUS
Emergency medicine	Failure to diagnose pulmonary embolism	Diagnostic errors and clinical prediction tools

Facts of the case

A 57-year-old man with a recent history of Wegner's granulomatosis presented to the emergency department (ED) with complaints of increasing shortness of breath over two days, a mild cough and weakness. The ED physician evaluated him and noted clear breath sounds bilaterally, a slightly elevated pulse at 126, and slightly elevated BP at 131/101. The ED physician ordered labs, which showed results of a slightly elevated BUN/creatinine but were otherwise normal. The ED physician read the chest X-ray as normal and instructed the man to follow up with his physician in two days if he was not feeling better. The ED staff discharged him with a diagnosis of upper respiratory disease.

Approximately six hours later, the man's wife found him unresponsive and called 911. Ambulance personnel began CPR, but the man did not respond. After communicating with the ED, the ambulance crew discontinued CPR and called the time of death.

The autopsy revealed that the man had a deep vein thrombosis (DVT) of the right leg and had died from a pulmonary embolism (PE). The man's wife filed a malpractice claim alleging failure to diagnose and treat PE resulting in death.

Disposition of case

The case was settled against the ED physician.

Patient safety and risk management perspective

The experts who reviewed this case could not support the ED physician's failure to recognize the severity of the man's condition given his history and presenting symptoms. The experts stated that the man had several symptoms potentially indicative of a PE, and the ED physician should have ordered further testing to rule out a potentially serious condition.

Pulmonary embolism — a difficult diagnosis

PE is a common and potentially fatal condition of blockage of the pulmonary artery. Most commonly a PE results from a DVT of the leg or pelvis that breaks off and travels to the lung. The Centers for Disease Control and Prevention (CDC) estimates that 60,000–100,000 Americans die of DVT/PE each year. Early diagnosis and treatment of PE is critical.

Diagnosing PE can be difficult due to nonspecific clinical presentations and because

many other medical conditions, such as heart attack or anxiety attack, cause similar symptoms. According to researchers, delays in diagnosis of PE are frequent despite current diagnostic strategies. Patients are sent home or admitted to hospitals with an incorrect diagnosis depending on clinical presentation or coexisting medical conditions. One third of patients who arrive at the ED with PE are misdiagnosed.[1]

To make a timely and accurate diagnosis, clinical prediction rules and diagnostic algorithms have been developed for venous thromboembolism (VTE). The American Academy of Family Physicians and the American College of Physicians developed a joint guideline on the diagnosis and management of VTE. A common approach is to use a validated prediction rule for risk stratification, screen with D-dimer assay as appropriate, and if necessary, perform the appropriate imaging studies to confirm or exclude VTE.[2]

Recent evidence and clinical practice guidelines from the American College of Chest Physicians and American Thoracic Society published in the *Choosing Wisely®* campaign don't recommend CT angiography in patients with a low pre-test probability of PE, stating that the cost and potential harm outweigh the benefits in patients with a low clinical prediction score followed by a negative D-dimer.[3]

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Resources:

CDC DVT PE
http://www.cdc.gov/ncbddd/dvt/index.html

Choosing Wisely®
http://www.choosingwisely.org/

ACEP Clinical Policy —
Critical Issues in the Evaluation and Management of Adult Patients Presenting to the Emergency Department with Suspected Pulmonary Embolism
http://www.annemergmed.com/article/S0196-0644%2811%2900097-7/pdf

ISCI Guideline VTE Diagnosis and Treatment
https://www.icsi.org/_asset/5ldx9k/VTE0113.pdf

LORI ATKINSON, RN, BSN, CPHRM
Manager, Research, Development & Education, MMIC
Lori.Atkinson@MMICgroup.com

Patient safety and risk management tips

- Identify risk factors for DVT/PE; some risk factors suggest greater risk than others:
  - *Fracture*
  - *Knee or hip replacement*
  - *Major surgery*
  - *Trauma*
  - *Malignancy*
  - *Pregnancy*
  - *Hormone therapy or oral contraceptive therapy*
  - *Congestive heart failure*
  - *Age ≥ 65*
  - *Prolonged immobilization*
  - *Previous DVT/PE*
- Utilize clinical prediction rules to determine the pre-test probability of DVT/PE (e.g., PERC or Wells rule).
- Rule in or out potentially serious causes of symptoms using clinical decision support (CDS) systems or web-based checklist systems.
- Adopt evidence-based algorithms for VTE diagnosis and treatment (e.g., ICSI Guideline for VTE diagnosis and treatment).
- Document thoroughly all informed consent discussions and all informed refusals from patients of recommended care

THE EXPERTS STATED THAT THE MAN HAD SEVERAL SYMPTOMS POTENTIALLY INDICATIVE OF A PE, AND THE ED PHYSICIAN SHOULD HAVE ORDERED FURTHER TESTING TO RULE OUT A POTENTIALLY SERIOUS CONDITION.

Etc.

Maggots

are returning in developing countries as a cheap, non-antibiotic treatment for infected wounds.[2]

36.2m

admissions in US registered hospitals in 2012.[1]

$830b

expenses for US hospitals in 2012.[1]

Percentage of U.S. physicians who admitted to practicing defensive medicine.[3]

Performed or ordered to avoid lawsuits:

- **35%** of diagnostic tests
- **29%** of lab tests
- **19%** of hospitalizations
- **14%** of prescriptions
- **8%** of surgeries[3]

82% of patients given access to their visit notes opened them at least once.

77% said they felt more in control and that it helped them adhere to medication.

Based on 19,000 patients who were given access to their visit notes with 105 doctors as part of a pilot program.[4]

1. 2012 American Hospital Association Annual Survey; 2. Med City News, September 4, 2014; 3. Jackson Healthcare Defensive Medicine Study, 2010
4. Med City News, October 2, 2014

INDELIBLE MOMENTS

There have been so many.

- Receiving my letter of acceptance to medical school and dashing to my husband's workplace to share the good news
- Being threatened by an angry patient to whom I had refused narcotics
- Being told my miscarriage was due to a "blighted ovum"
- Seeing my beloved grandfather lying in a coma after a massive stroke
- Feeling I would split in two as I pushed out our second child
- Opening the door of my office one day to find a sheriff handing me a subpoena and a notice of a malpractice suit against me
- Holding a woman who had collapsed in my arms and who was beseeching me to save her dying husband
- Listening to the wails of a grieving mother whose 4-year-old child had been found at the bottom of the family swimming pool
- Continuing CPR, way beyond hope, on an infant who had died of SIDS, just so her mother could see that we had "tried everything"
- Telling a 50-year-old mother with a 9-year-old son at home that she had a metastatic lesion in her liver
- Telling a mom and a dad that their young adult son was not likely to wake up after his severe head trauma and witnessing their overwhelming pain
- Watching my best friend die of metastatic breast cancer in an ICU on a ventilator, while her confused and scared family demanded more interventions because they had lost faith in her care team

These are just some of the powerful moments seared into my memory, moments whose recollection can bring me back instantly to the intense emotions that surrounded them — great joy, fear, surprise, sadness, pain, shame.

I suspect the same may be true for you. A career in medicine seems to guarantee that we will experience a great many indelible moments. Being docs also ensures that we will play a leading role in creating the moments that become indelible for our patients and their families. We bring our own baggage to this daunting role.

As an ER doc, I took a special interest in learning about the most compassionate and caring way to deliver bad news. I sensed that the way I framed and communicated such news — the way I participated in the encounter — could have a large impact on how a moment would become inscribed for someone else. My guess is that doing this well doesn't come naturally to most people; it certainly didn't to me.

In my medical training, there was a strong emphasis on staying objective, which meant that sometimes the patient got lost in the process, becoming the "chest pain" in room A or the "belly pain" in room 9. When I later served as medical director of our emergency department, it fell to me to return the calls of patients or family members who had complained about their treatment. A consistent theme in these complaints (one confirmed by patient satisfaction surveys) was the perception and feeling that they had not been treated with kindness or with dignity and respect. We have room to improve in this arena.

Research on why patients and families file lawsuits and claims shows that most people sue doctors because they are angry about how they've been treated when things go wrong and they're looking for answers to their questions. In this context, it is easy to see the

INDELIBLE MOMENTS

value of learning ways to hold difficult conversations or deliver bad news. These are the kinds of skills taught in the web-based continuing medical education courses produced by Empathetics, a company whose mission we heartily support and whose services we promote. Empathetics training uses research into the neurobiology and physiology of human interactions to help clinicians develop knowledge and skills to promote more empathetic connections with our patients. (For more information on Empathetics, email PatientSafety@MMICgroup.com.)

So what does empathy really mean? It means trying to imagine and understand what it might be like to stand in another person's shoes. What would it feel like to be told that the person you loved most was very sick, or had died? How would you want this information conveyed to you? For those motivated to learn how to be more empathetic, the good news is that there are research-based, tried-and-true techniques that work.

Last year, I attended a University of Minnesota Medical School alumni reunion. I had the honor of sharing breakfast with an 80-ish retired family medicine doc, who had settled and practiced in the Northwest. When I told him about our efforts at MMIC to support doctors in the midst of litigation, his eyes teared up. He told me about a time when he responded to a knock on his door and was met by a sheriff with a summons in hand. He still has nightmares about this event and about the emotional trauma of being sued. Another indelible memory.

Know that we are here to support you through your most difficult times and that we are doing our best to learn and to share new and better ways to create and to live with those indelible moments. What are your indelible moments? Write to me at my email address below.

LAURIE C. DRILL-MELLUM, MD, MPH
Chief Medical Officer, MMIC and UMIA
Laurie.Drill-Mellum@MMICgroup.com

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The Patient Experience

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