MACM

RISK MANAGER

Fall 2019

CONTENTS

Dear MACM Insured:

Welcome to the latest copy of the *Risk Manager*! We hope this issue finds you well and that your practice is productive and growing.

In this issue of the *Risk Manager*, we offer our thoughts on good office note documentation and provide examples of some poor documentation seen over the years. In addition, a case from the MACM Claims Department files is reviewed. This case resulted from a misdiagnosis involving a mid-level provider. I hope those of you working with mid-levels will take the time to read this article and call if you have any questions.

If you have not already taken advantage of MACM's online CME program, please do! Instructions to gain access to hundreds of educational hours are included on pages 6 and 7 of this publication.

As always, if there is anything that anyone in Risk Management can do for you, do not hesitate to let us know. Happy Fall!

Sincerely,

Kathy Stone, RN

Kathy Stone, BSN, RN
Vice President of Risk Management

A CLOSER LOOK
MACM ONLINE EDUCATION

DO YOU NEED PRESCRIBING EDUCATION HOURS?

Through a series of courses, MACM is now offering online CME that meets the Mississippi Board of Medical Licensure's requirements of five hours on the prescribing of controlled substances. Following are the courses that meet this requirement and are now available at no charge to MACM insured physicians:

- Prescribing Controlled Substances – 1.5 CME Hours
- Controlled Substances Series: Drug Diversion Prevention – 0.75 CME Hours
- Controlled Substances Series: Best Practices for Prescribing – 1.25 CME Hours
- Controlled Substances Series: Fundamentals of Addiction and Addiction Treatment – 1.25 CME Hours
- Opioid Mortality: What Prescribers Can Do - 2.0 Hours
- EFM Case Study #19: Substance and Opioid Use Disorders in Pregnancy – 2.0 CME Hours

See pages 6 and 7 to learn how to sign up and access this information.

Medical Assurance Company of Mississippi
404 West Parkway Place
Ridgeland, Mississippi 39157
601-605-4882
www.macm.net

WHAT DOES GOOD OFFICE NOTE DOCUMENTATION LOOK LIKE?

By Kathy Stone, BSN, RN, Vice President of Risk Management

A physician recently asked what was truly important to include in the documentation of a patient's visit to the office. This was an excellent question and one the MACM Risk Management Department has been in the business of answering since its inception 30 years ago.

After years of experience in reviewing claims and tens of thousands of office notes, the following information is most relevant to document in regards to the patient's healthcare and the physician's malpractice defensibility. Please keep in mind, this article is NOT about docu-

mentation for billing or even quality measures. Those are issues that the staff of each clinic must address themselves.

History of Present Illness (HPI)/Interval History

This aspect of the note describes what the patient is telling the physician regarding the reason for being there, *i.e.*, what has happened to bring the patient in to see the physician. If the patient has been seen previously, this part of the note outlines everything health related that has happened since the last visit, including how the patient responded to the physician's previously prescribed treatment. The follow-up on previous treatments is very important but often lacking in the documentation.

The HPI and the interval history are primarily derived from listening to the patient explain what is going on, and it is important that this information be documented and not just kept in the physician's head.

Assessment/Diagnosis

Sometimes the diagnosis can be difficult to find in an office note, or there are so many diagnoses/problems that it can be challenging to determine which one(s) truly applies to each specific visit.

For instance, a patient who is being followed for hypertension and diabetes comes in with upper respiratory infection (URI) symptoms. This visit may have a note which appears to focus on the chronic conditions rather than the acute symptoms that are the real reason for the visit. (This can apply to the HPI as well.) Before electronic medical records, physicians would routinely document their differential diagnoses. Now, this can be difficult to do in an EMR note which can even assign an inaccurate diagnosis that is carried forward from then on. It might be helpful to document those differentials in another section (perhaps the Plan) using a narrative that explains they are differentials rather than a dropdown list that makes them appear as fact. On the other hand, routinely listing symptoms rather than arriving at a diagnosis is not appropriate either. If a patient has chronic symptoms, there should be documentation that effort is being made to identify the cause.

Plan

As with all other aspects of a note, the EMR may bring the previous plan forward, which may not get updated appropriately. Also, the plan should be supported by documentation elsewhere in the note, either in the patient's history in which a relevant symptom is described or by a finding in the physical exam that requires further investigation. At times, a test result may be the only indication for some diagnoses and treatments.

While this section contains the physician's orders, it may also include any instructions or education the physician and staff conducted with the patient. In other words, this section may be where the physician can document what was told to the patient.

It is not necessary to document a full review of symptoms (ROS) at every single visit. Doing so could be a trap to physicians because the ROS may have symptoms documented differently than what is described in the rest of the note. Also, it can create liability for the physician to address each complaint. The physician understands that not all patient complaints require immediate evaluation and intervention and should be viewed in the context of the rest of the visit. However, a jury may not be able to make that distinction.

Take, for instance, our patient with the URI symptoms. It is not necessary to determine if the patient is having urinary incontinence or anxiety at this visit – unless it is the physician's medical judgment that those symptoms might be relevant to the current complaint. If that is the case, the information could be elicited by the physician and documented in the HPI section. The same patient may complain of chest tightness with inspiration which a staff member may note as chest pain. It is then incumbent upon the physician to address this chest pain complaint, which is really not chest pain at all, and document clearly the patient's specific complaint. Otherwise, if weeks or even months later this patient suffers a cardiac event, a plaintiff attorney will point out the patient complained of chest pain, and since the physician did not address it, he is, therefore, liable.

Before EMRs, a ROS may have been done at an annual visit. But many physicians may never have documented one. They asked relevant questions

based on the history and reason for the visit that the patient provided to them. That said, it is a good idea to obtain a full ROS at least annually to thoroughly evaluate the patient's health status.

Pay attention to the physical exam (PE) documentation. Exam documentation of 14 different body systems on our URI patient is probably unnecessary and bloats the note. Furthermore, if every element of the documented exam is not accurate, it can pose problems medically and legally. Should the document ever be involved in a legal battle, an incorrect exam entry can cast doubt on the rest of the note.

Please understand that I am NOT saying a PE should not be documented, but simply that it should fit the situation. Certainly, it is important to note pertinent exam findings – those related to the patient's condition or reason for the visit.

It is highly unlikely that every patient needs, or gets, a full cranial nerve evaluation, reflex checks, or a range of motion assessment. And if the patient was not observed ambulating, do not document that the patient's gait is normal.

The EMR template should be reviewed to ensure it contains specific ROS and exam findings. While reviewing the template, look for the use of the term "normal". It is preferable that you describe your findings. A description of the specific exam findings needs no further explanation whereas "normal" may mean something to one person and yet another thing to someone else. This could leave your documentation open to a plaintiff lawyer's interpretation.

To sum up, what is often lacking in office notes can be the most important pieces of information:

- What the patient told the physician (history/HPI)
- What the physician's determination and decision was (diagnoses and plan)
- What the physician told the patient

The communication loop between the physician and patient should be closed and then documented fully in the note. Just remember: Tell the patient's story in the note.

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EXAMPLES OF POOR DOCUMENTATION

- Reason for visit/interval history is simply documented as "prescription renewal".
- Reason for visit/interval history is "patient doing well" with no notation of how patient responded to new treatment prescribed at last visit.
- Nausea and vomiting is noted in the ROS, but there is no reference to this in the rest of the note – or the physician specifically documented that the patient denies nausea and vomiting.
- Every patient has a full cranial nerve evaluation documented on every visit.
- Noted normal gait when patient is an amputee or wheelchair bound.
- Exam documentation reflects normal findings even though the patient presented for an obvious problem, such as a rash or laceration.
- Breast exam detailed on every patient and every visit in a urology clinic.
- ENT exam detailed on every patient and every visit in an orthopedic clinic.
- Exam details documented for multiple systems at every visit but none address the patient's actual complaint.
- Exam documentation for chronic pain patients does not address the actual pain complaints.
- Antibiotic prescribed, but no information to support this plan – no complaint, exam finding, or test result related to the antibiotic prescription.
- No diagnosis related to the treatment plan.
- "Fatigue" repeatedly noted as a diagnosis with no indication of workup and no actual diagnosis to explain the patient's symptom of fatigue.
- No treatment plan documented for a new diagnosis such as diabetes mellitus.

MACM OFFERING OVER 150 FREE ON

MACM is now working with Medical Interactive, a national provider of risk management and patient safety education, to provide our physician insureds access to free online CME and MOC credits. This educational material is written and presented by a national faculty of experts and medical educators.

MOC CREDIT

NO COST TO MACM INSURED PHYSICIANS

Steps to access the online CME:

1. Open the MACM website at *www.macm.net*.
2. Sign in to the Member Log In section of the website using your email address and password currently on file with MACM.
3. Once you have signed in to Member Log In and your personalized home page is open, click on the Education tab and then click on the Continuing Medical Education button.
4. Click on the Medical Interactive CME button. Doing this will allow you to leave the MACM Member Log In section of the MACM website and open a new browser for the Medical Interactive site.
5. **PLEASE NOTE!** The first time you attempt to use the Medical Interactive site, you must create a separate user name and password. The information you use to log in to the MACM Member Log In will not work on the Medical Interactive site.

NLINE CME COURSES TO PHYSICIANS

Medical Interactive has a series of courses to address the national need for controlled substance education, and the courses meet the requirements of Mississippi's five hours for prescribing controlled substance education.

97 percent of the Medical Interactive CME courses have Maintenance of Certification credits, with 17 medical boards accepting the CME courses. Patient safety points are available on applicable courses.

ONLINE LIBRARY TOPICS INCLUDE:

- Controlled Substances
- Diagnostic Error
- Documentation
- Medical, Legal & Ethics
- Medication Therapy
- Perinatal
- Practice Management
- Professional Interaction
- Provider Burnout
- Quality Improvement
- Risk & Claims

Should you have any questions or comments, please contact the MACM group administrator:
Yevgenia Wilkerson, Senior Administrative Assistant for Risk Management
yevgenia.wilkerson@macm.net | (601) 605-4882 | (800) 362-2912

CASE STUDY

MISDIAGNOSIS INVOLVING A MID-LEVEL PROVIDER LEADS TO SETTLEMENT

A 58-year-old male presented to a family medicine clinic with extreme weakness, shortness of breath, and productive cough. He had a history of uncontrolled insulin-dependent diabetes mellitus, hypertension, and hyperlipidemia. He and his wife reported to the nurse practitioner (NP) that two weeks earlier he had been diagnosed and treated for pneumonia at another facility. The night before, he had resorted to using his parents' oxygen and breathing treatments to address his shortness of breath. The oxygen saturation at this visit was 87 percent on room air, which rose to 90 percent on oxygen. Pulse was 127; a chest x-ray was normal. The NP diagnosed the patient with bronchitis and pneumonia, ordered antibiotics and cough medication, and instructed the patient to continue to use his parents' oxygen and nebulizer.

The next day, the patient's wife called the clinic and left a message. When the LPN returned the call, the wife informed the nurse that the patient had used oxygen all night and this morning he could not walk 20 feet without extreme shortness of breath. The LPN discussed the situation with the NP and called the wife back to instruct her to take the patient to a hospital emergency department or urgent care clinic. However, the wife informed the LPN that the patient had collapsed, was not breathing, and she had called an ambulance. The patient never recovered and was pronounced dead in the hospital emergency department. It was determined he had suffered a myocardial infarction.

Issues in This Case:

- Failure to diagnose a myocardial infarction
- Failure to consult a physician
- Failure to admit to a hospital
- Did not repeat pulse or O2 saturation to determine if patient was more stable prior to discharge from the clinic
- Did not do EKG
- Follow-up was only if needed with no appointment made
- Recommended patient use someone else's medication and oxygen
- Documentation of three phone call interactions in one note made it difficult to determine the timing of events

The lawsuit was eventually settled for more than $200,000.

Why review this case?

1. The issues identified and lessons learned from this case apply to any specialty that works with mid-level providers. Some of the problems have been identified in physician cases as well.
2. The training of nurse practitioners is quite varied in character and quality.
3. The use of mid-level providers continues to increase and expand into virtually every care setting and specialty making it ever more likely that you will find yourself working with a mid-level provider in the near future, if you aren't already doing so.

Mid-level providers can be an excellent extension of your care; but you as the physician must ensure they are caring for your patients in a manner that meets your expectations and follows the Mississippi Board of Medical Licensure regulations. How do you do this?

Education and Experience

Before hiring a mid-level provider, review and compare the provider's previous clinical experience as well as the type and location of the training received in school. Nurses can now enter directly into nurse practitioner schools from their nursing school program without having worked as a registered nurse. Most nurses will tell you, and physicians surely understand, that much of what they learned came from hands-on practice. As for the nurse practitioner education, inquire whether the applicant's program was done purely online or whether it involved regular skills assessments by unbiased professors of nursing. It has been our experience that Mississippi-based traditional nursing schools do an excellent job of training and overseeing their nurse practitioner students, even those who are participating primarily online.

Mississippi Board of Medical Licensure (MSBML) Requirements

The MSBML is responsible for issuing licenses to and governing physician assistants (PA). The regulations regarding physician assistants can be found in the MSBML Administrative Code Title 30, Part 2615: The Practice of Physician Assistants. We encourage you to closely review the entire section if you

are currently working with a PA or plan to do so. You can find the regulations at the MSBML website at this address: www.msbml.ms.gov/administrative.

While the Mississippi Board of Nursing issues licenses to and governs nurse practitioners, physicians must still abide by the MSBML's regulations regarding practicing with nurse practitioners. The regulations regarding nurse practitioners can be found in the MSBML Administrative Code Title 30, Part 2630: Collaboration, Chapter 1: Collaboration with Nurse Practitioners. Again, we encourage you to review the entire section if you are currently working with a NP or plan to do so.

The MSBML mandates physicians conduct a quality assurance/quality improvement program for both NPs and PAs. The specific requirements are outlined in the sections noted above.

The Mississippi Board of Medical Licensure has made recent changes to its rules to foster the use of mid-level providers as primary care providers in rural areas of Mississippi. The same language was added to the rules for both physician assistants and nurse practitioners and can be found in their respective sections. Specifically, it states that there will be no mileage restriction placed on the physicians and mid-level providers if the following conditions are met:

1. The collaborative agreement or protocol must be between a primary care physician and a primary care NP or primary care PA.
2. The physician is in a compatible practice (*e.g.* same specialty, treats the same patient population) with the NP or PA.
3. The physician utilizes electronic medical records (EMR) in his or her practice and also utilizes EMR in the formal quality improvement program. This was added so the physician could review the mid-level provider's charts remotely via the EMR as well as have ready access to patients' charts should the mid-level provider contact the physician with a patient-specific question.
4. The physician practices within the State of Mississippi for a minimum of twenty (20) hours per week or eighty (80) hours per month (does not include telemedicine).

The MSBML also recently expanded the definition of Primary Care to include Mental Health so that it now encompasses "Family Practice, General Internal Medicine, Mental Health, Women's Health and/or General Pediatrics".

RECOMMENDATIONS FOR WORKING WITH MID-LEVEL PROVIDERS

- **Ensure they are trained to your satisfaction**
  Ask questions about the provider's program and the type and amount of hands-on experience they received. Consider conducting your own skills assessment or patient encounter simulation to assess the provider's clinical acumen.
- **Monitor them closely**
  Require new or less experienced mid-level providers to shadow you for a time. Then transition to a proctoring type of approach in which you "shadow" to observe the provider's interactions and clinical thought processes with your patients. Once you trust the provider to care for patients without direct oversight, consider meeting together daily for a period of time during which you discuss each patient and the rationale for the clinical treatment decisions. If the mid-level does not have experience in your specialty, this process will necessarily take longer. Don't neglect to review the provider's documentation to ensure it is accurate and thorough.
- **Be aware of practice limitations**
  Mid-level providers should not practice outside their own scope OR the scope of practice of their supervising physician. In other words, a dermatologist should not employ and supervise a mid-level provider to deliver primary care. Additionally, the Mississippi Board of Nursing forbids a nurse practitioner (or any other licensed nurse) from delegating nursing functions to a non-nurse. For example, a NP cannot ask a medical assistant to administer a vaccine or call in a prescription.
- **Be accessible**
  This not only applies to your availability physically or by other means of communication but also to your attitude. If a mid-level provider feels that you consider it a bother when your input is requested, the provider will undoubtedly do so less and less which can result in an incorrect decision.
- **Set a good example**
  Mid-level providers often take on the characteristics of their supervising physicians, good and bad.

MSPQC

UPCOMING MEETING ANNOUNCED

Editor's Note: Since 2014, MACM has supported the efforts of the Mississippi Perinatal Quality Collaborative and its work to promote healthy mothers and babies. As part of our continued work with this group, following is an update on recent activity and the group's upcoming annual meeting. We encourage our insureds, especially the Ob-Gyns, to consider attending this year's meeting in November.

Launched in November 2014, the Mississippi Perinatal Quality Collaborative (MSPQC) is a statewide partnership working to improve care for mothers and babies in Mississippi through evidence-based quality improvement initiatives. These initiatives provide education in and support of healthcare providers, nurses, and hospital teams on the implementation of safe, consistent, evidence-based obstetric and pediatric practices that can improve health and save lives. Partners include the Mississippi chapters of the American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP), the Mississippi Academy of Family Physicians, Mississippi Hospital Association, and multiple provider groups and hospital systems. Partial funding for the MSPQC is through the Centers for Disease Control and Prevention's Division of Reproductive Health.

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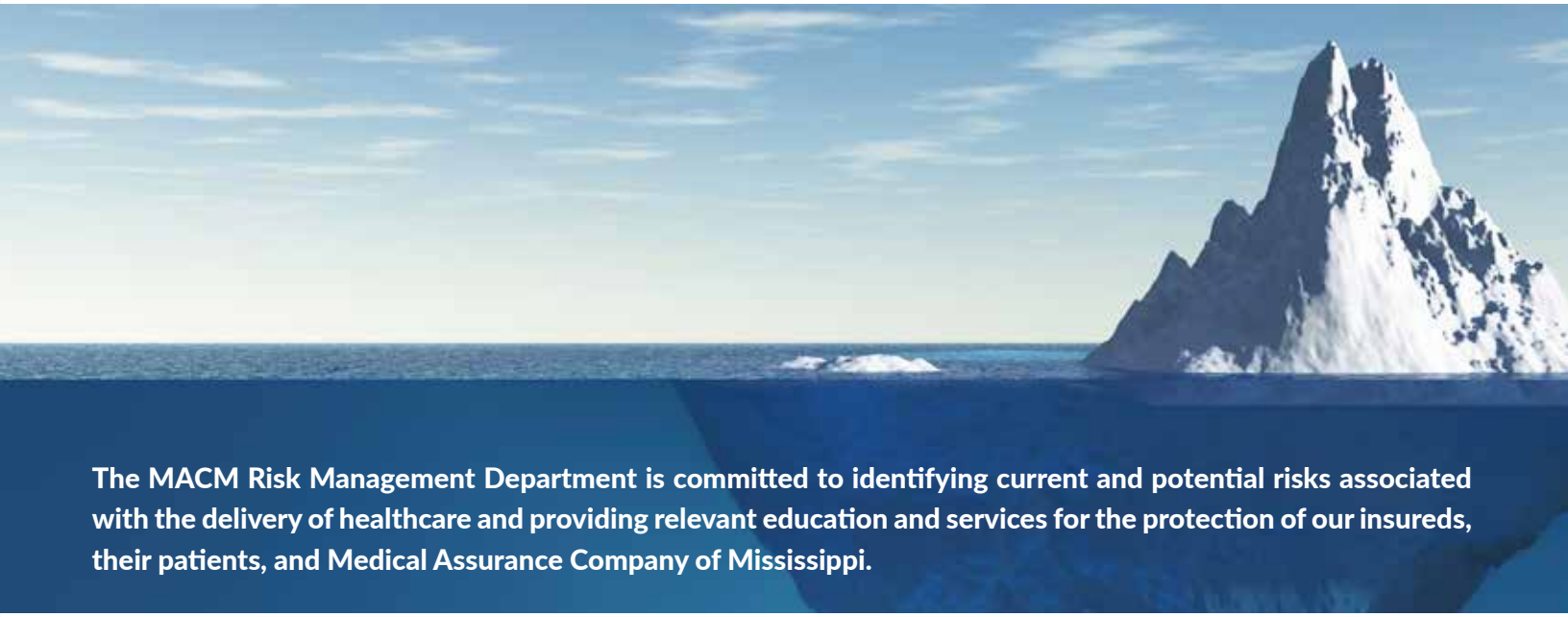
MACM Risk Management



The MACM Risk Management Department is committed to identifying current and potential risks associated with the delivery of healthcare and providing relevant education and services for the protection of our insureds, their patients, and Medical Assurance Company of Mississippi.

At Medical Assurance Company of Mississippi, we believe protecting our insureds from litigation is just as important as the service we provide after a suit is filed. The primary focus of our physician insureds should be the health and well-being of their patients. Our responsibility is to help you keep that focus, while we work to improve the healthcare delivery system.

Consider contacting one of our Risk Management Consultants about any of the following services we offer at no cost to MACM insureds.

- **Onsite Survey.** Through these evaluations, our staff can analyze the risk management systems and documentation within your practice to offer suggestions for improvement.
- **In-Service Education.** With customized presentations and training, our staff can meet the needs of our individual insureds.
- **Consultations by Telephone and Email.** Our consultants are located in Mississippi and are available to answer questions from insureds promptly and professionally.
- **Publications.** Our insureds receive information that is timely through *Risk Manager Alert* email blasts, as well as more in-depth information through our *Risk Manager* publication.
- **Reference Materials.** These written bulletins are available to our insureds and are designed to help in specific circumstances that come up daily in a medical practice, such as withdrawal from patient care.
- **Educational Opportunities.** In addition to the knowledge of our in-house staff, MACM has contacts across the U.S. and makes this expertise available to our insureds through webinars and conferences.
- **Presentations and Speaking Engagements.** The Risk Management Staff frequently presents at conferences offering suggestions to improve the healthcare delivery system and promote good medical-legal practices to protect our insureds.

Contact us today to learn more about our services.

www. macm.net | rskmgt@macm.net | 601.605.4882

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404 West Parkway Place
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601.605.4882
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MSPQC members work collaboratively through three divisions: Neonatal, Obstetric and Family/Public Health. All initiatives are data-driven and endorsed by MSPQC partners and national multidisciplinary organizations. MSPQC promotes Maternal Safety Bundles developed by the Alliance for Innovation on Maternal Health (AIM), in which ACOG is the lead partner. Because obstetric hemorrhage is the most common serious complication of childbirth (and its rate is increasing in the United States), the 'Every Drop Counts' Obstetric Hemorrhage Initiative was launched in November 2016. Neonatal and Family/Public Health projects include the Golden Hour project, designed to support premature infants in the first hour of life, the Neonatal Abstinence Syndrome project, addressing the management of infants exposed to opioids and Safe Breastfeeding Practices, in partnership with the Communities and Hospitals Advancing Maternity Practices (CHAMPS) program. All initiatives are promoted statewide through presentations and simulations with assistance from area hospital providers.

The Sixth Annual Meeting of MSPQC is scheduled for **November 15, 2019**, at the Hilton Hotel and Convention Center in Jackson. Registration opened in September 2019 at https://mspqc.org. The conference is free and features experts in obstetrics and neonatal care from across the country. Because Mississippi maternal mortality review (https://msdh.ms.gov/msdhsite/_static/31,0,299,359.html) data shows that the leading causes of maternal death in Mississippi are consequences of hypertension and heart disease, a new Peripartum Hypertension and Heart Disease Initiative will be introduced at the meeting with presentations by nationally recognized experts in the field. Medical providers that participate in MSPQC project activities are eligible to receive ABOG Part IV Maintenance of Certification credit. There are multiple opportunities for physicians to participate and lead educational efforts with MSPQC.

For more information, or to become involved, please email director Dr. Charlene Collier, FACOG, at Charlene.Collier@msdh.ms.gov.

Because Mississippi maternal mortality review (https://msdh.ms.gov/msdhsite/_static/31,0,299,359.html) data shows that the leading causes of maternal death in Mississippi are consequences of hypertension and heart disease, a new Peripartum Hypertension and Heart Disease Initiative will be introduced at the meeting with presentations by nationally recognized experts in the field.