Medical Assurance Company of Mississippi

Risk Manager

August 2014

Medical Assurance Company of Mississippi
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RISK MANAGEMENT
Enhancing Patient Care • Supporting Physicians

MEDICAL ASSURANCE COMPANY OF MISSISSIPPI
Established 1976

Welcome to the latest issue of the Risk Manager!

In this issue, we focus on the changes we continue to see as part of our work with MACM® insureds and within the practice of medicine. These changes are hitting medicine so fast and so furiously that most healthcare providers feel as though they are in the middle of a storm every day.

Our hope through this magazine (and through our work each day) is that, by providing information on relevant topics, our insureds will be able to better cope with the ever-changing landscape of medicine and weather the storm that is medical practice in 2014.

In our continued coverage of controlled substances and drug diversion issues, we feature an interview with leaders of the New Orleans Division Office of the Drug Enforcement Administration (DEA). Through our conversations with these leaders, you will gain insight into problems they experience in their work and suggestions as to how to work with the DEA when there are concerns in order to protect yourself and your staff. The DEA wants to be a resource for you, and we hope that you will take advantage of this organization.

MACM continues to see communication difficulties between our insured pathologists and/or radiologists and the referring physicians when unusual or unexpected results are evident on a test. This article will outline strategies for everyone involved as to how the results of the tests can be communicated efficiently and information is used to treat the patient appropriately and in a timely manner.

As hospitals and physicians continue to work in close relationships, communication in a productive manner about patient safety issues becomes important. As a physician, the way that you communicate with hospital administration will go a long way to achieving the result that you want. We offer hints on how to facilitate this conversation among your peers and hospital staff.

Each year, our staff reviews data of risk management concerns seen in the previous year's Claims Committee meetings. These data are analyzed and used to determine the work to be done by our department. In this issue, we offer our review of the 2013 claims and, to make this information even more relevant to your practice, we are citing specific examples of the problems found.

On a personal note, everyone at MACM has been coping with the tragic and very sudden loss of one of our employees. Sharon Pell served as Senior Administrative Assistant in the Risk Management Department. While our Risk Management Consultants were the ones most seen by our insureds, it was Sharon's voice you would probably recognize. Sharon helped our department coordinate education efforts by managing the registration process for our insureds. She was the person that was in the office every day to help answer your questions. Sharon died in the tornado that came through Rankin County in April and we miss her every day.

At the same time, with every difficult situation, life moves forward and we are so happy to welcome Yevgenia Wilkerson as the newest member of the Risk Management team. Yevgenia is our Administrative Assistant and is just a phone call or email away if you need to get in touch with your Risk Management Department.

In addition to Yevgenia, the Risk Management Department is thrilled that Dr. Gerry Ann Houston has become the MACM Medical Director. Dr. Houston will serve as a resource for us, and you will see her as a contributor to future issues of this publication.

We hope you will find the information in this magazine helpful and of value. If you have any comments about this publication or suggestions for future topics, please do not hesitate to let me know.

Sincerely,

Maryann Wee, RN
Director of Risk Management

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Working with Hospitals for Patient Safety Concerns

By Maryann Wee, RN
Director of Risk Management

On a fairly regular basis, we receive calls from our insured physicians in which they have a concern about safety issues in the hospital where they practice. Most of the time, our insured will want MACM to "take a stand" and strongly tell the hospital that we will not cover the physician for the risk that is the area of concern.

We appreciate every one of these calls and encourage our insured physician to call us as often as they need to contact us. However, from a relationship perspective, we cannot get involved between our insured and the hospital or facility in which they practice. What we will do is offer some guidance and suggestions of how to develop a plan of action to both assess the problem and work within the facility's organization to solve it.

Below is a list of strategies that we suggest a physician use to address patient safety concerns in a productive manner.

Resist the impulse to storm the administrative office.

Barging into the administrative offices with fire in your eyes will not accomplish much except to make people mad and question you. If you fly off the handle too often, you will be labeled as a "disruptive physician" and may even be ignored when expressing future problems. Before walking in to the administrative offices, take a deep breath and develop a plan to present your issue to administration effectively.

Do the research.

Get the facts straight. Be prepared to answer the following: How could it or is it, adversely affecting patient care/safety? How often has the problem occurred? Is it a regular occurrence on any specific time of the day or day of the week? Does it involve a specific person? Have examples and documentation with all the facts written down. Spend time outlining the problem and gather data to support your request.

Build a coalition with other healthcare providers.

If you can include physicians who have political power, such as the medical director or chief of staff, and that are economically important to the hospital, it will help bolster your position. The more physicians who will agree it is a problem . . . the stronger your case will be. Don't forget to enlist other healthcare providers, such as representatives from nursing, who can give their side of the story. Present them the facts that you have gathered and see if they have other examples that they have encountered.

Schedule a meeting with all involved parties and be sure to follow chain of command.

Include people who can assist in presenting your case, especially if they have first-hand knowledge of the issue. Make sure the administrative staff, which deal with the area and have the authority to act on it, are included. When possible, include the highest level of supervision, but don't bypass the established chain of command.

Prepare for the meeting.

Use your research to outline the problem. If you can, propose a possible plan of action. Keep personal emotions and conflicts out of it! The idea is not to place blame on anyone but to point out a problem and find a solution.

Keep the focus of the meeting.

Present your facts and then listen carefully to what is being said in response. When possible, it is really a good practice to have another party with you who can take notes.

At the end of the meeting, summarize what was said by restating: 1) the concern; 2) the plan of action that was decided upon; 3) who is responsible to address the concern; and 4) the timetable to expect a response.

Document results of meeting in a letter or email.

Afterwards, send a letter to everyone who participated in the meeting that outlines the problem and the agreed upon plan of action, with deadlines. Documenting the meeting and the decisions made in writing gives more credibility to your argument and allows you again to summarize the plan of action. Keep a copy of the letter for your records and send copies to all concerned parties.

Follow up:

Problem Solved - Once the problem is resolved, remember to thank the administration and everyone else involved in the process in writing. Everyone likes recognition, and this will put you in good standing if you have an issue come up in the future.

Problem Persists - If the problem has not satisfactorily been addressed by the deadline that was agreed upon or significant progress has not made, continue to persist. Keep the issue in the forefront by again putting your concerns in correspondence, with copies to all appropriate parties. Keep emphasizing the continuing concern to patient safety and give examples of problems as they occur. Again, keep all correspondence to verify you have regularly alerted the administration about the problem.

Even in this challenging era with decreasing reimbursement and increasing demands on both the healthcare providers and the healthcare facilities, physicians must continue to be the advocate for appropriate and safe healthcare for their patients. Making the effort to do this is not easy, but, with some effort and organization, it can be done.

New Physician Orientation Now Available Online

Since 2003, any physician that became a new insured of MACM was required by the Board of Directors to attend an orientation session. In this meeting, new insureds received an overview about the Company and its staff, as well as the basics of our Underwriting, Claims and Risk Management processes.

For the first 10 years of the New Physician Orientation program, members of the Risk Management and Legal Departments traveled Mississippi – meeting with 2,055 physicians in 90 programs in hospitals, convention centers, restaurants, and any place that was conducive to a business meeting.

Beginning this year, the meeting format changed to an online program allowing new insureds to MACM the convenience of completing this mandatory program on their schedule. This online format also freed up time and reduced expenses for our Risk Management and Legal staff.

If you are a new insured to MACM or are a clinic manager for a soon-to-be MACM insured, the orientation session that you (or your new physician) are required to take as terms of your professional liability insurance is available in the Members Only section of the MACM website. Information to access the orientation program is available through the MACM Risk Management Staff. CME credit is available for a portion of this program.

www.macm.net

The Year of the Obstetrician:

Update on OB/Labor & Delivery Education Initiative

In 2013, an education program was begun for the obstetricians insured by MACM and the labor and delivery staff in the hospitals where they deliver. The purpose of this education program was to increase awareness among insureds and hospital staff about the various actions that could lead to a medical malpractice claim. The components of this program were based on a review of the MACM Claims Department files for the past 10 years.

As part of this program, the labor and delivery nurses where MACM insureds deliver were offered the most recent GE Healthcare Fetal Monitoring Course at no cost to the hospital. This course has been a requirement of coverage for the past several years for the insured obstetricians.

"The thought was that to improve communication between our insured obstetricians and the nursing staff, who work with each day, we needed to have them talking the same language," Maryann Wee RN, Director of Risk Management, said. "With both constituencies taking the same course, we are hoping to improve their communication during a patient's delivery."

Since 2013, 11 of the 26 hospitals in Mississippi where MACM insureds deliver have signed up to participate in offering this Fetal Monitoring Course to their labor and delivery staff. Of those 11 hospitals, 149 of the 271 nurses registered have completed the course.

Another part of this program was to provide educational materials to these same two audiences that would cover risk management concerns and strategies. Since the beginning of this program, three comprehensive articles have been published and distributed. The first article reviewed the Claims data of obstetrics during the last 10 years. The second article concentrated on improving communication between the obstetrician and the labor and delivery staff. And, the third article released this past spring, offered assistance in preparing for obstetrical emergencies. Future articles are scheduled for distribution later this year.

The next segment of this educational initiative will take place on April 10, 2015 when MACM will provide a joint CME and CE educational program for obstetricians and the labor and delivery nursing staff. This one-day seminar – *The Power of Teamwork for a Healthy Mother and Baby* – will be held in Ridgeland and feature national speakers on topics such as Fetal Monitoring Strip interpretation, obstetrics clinical issues, and fostering a team approach in L&D.

Wilkerson joins MACM as Administrative Assistant

On June 16, 2014, the Risk Management Department welcomed a new member to the MACM team. Yevgenia Wilkerson is now assisting the Risk Management staff and insureds as an Administrative Assistant.

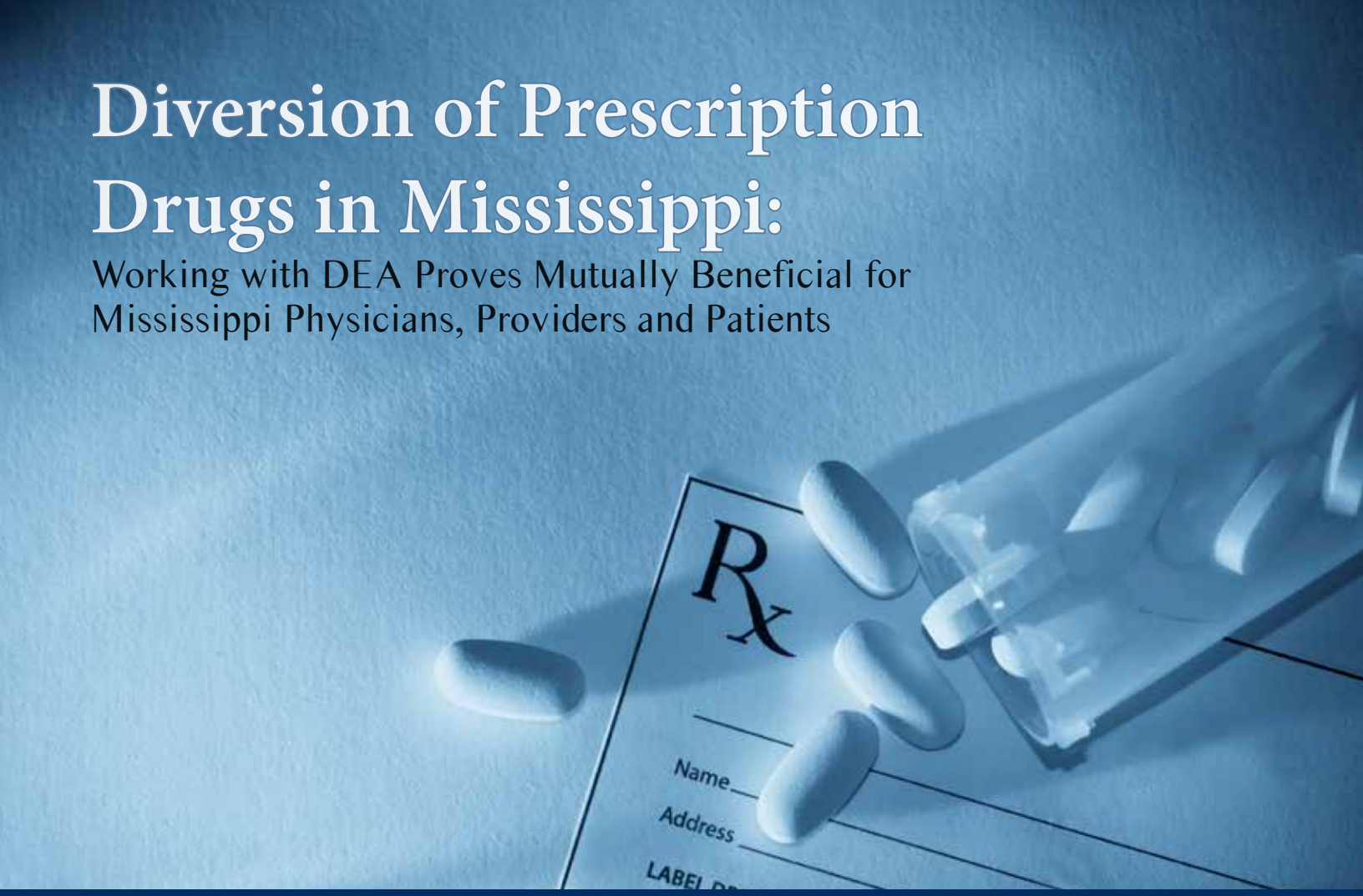
Prior to coming to MACM, Wilkerson worked in several medical clinics, but had never had the opportunity to work with MACM.

"Even though I worked in clinics, I had never encountered MACM, but when I started asking people, I found out that it is a well-respected company in the medical community. The people here are professional and very knowledgeable and very interested in helping our insureds," Wilkerson said.

At MACM, Wilkerson will be a resource for insureds working with the Risk Management Department by answering questions, managing the registration for the educational programs offered, and being in the office to assist as needed. She is also a Certified Professional Coder-Apprentice.

Diversion of Prescription Drugs in Mississippi:

Working with DEA Proves Mutually Beneficial for Mississippi Physicians, Providers and Patients



"We want a good, mutually beneficial relationship with practitioners in Mississippi, where we all work together to solve the problem of drug diversion. We want the practitioners in Mississippi to understand that we are not the enemy and that we want to work with our registrant population."

These are the wishes of Special Agent in Charge Keith Brown, head of the New Orleans Division of the Office of Diversion Control for the Drug Enforcement Administration. This district includes the state of Mississippi, as well as Louisiana, Alabama and Arkansas. In a conversation recently with the Risk Management staff of MACM, Agent Brown talked about some of his goals for working with the healthcare providers in Mississippi: To do a better job of promoting the resources of his organization and to develop a strong educational relationship with the providers.

The agents of the local office of the DEA, specifically the Office of Diversion Control, want to be a resource for information, and a contact when needed, for Mississippi physicians. Through their office in the McCoy Federal Building in Jackson, the DEA wants to work together with healthcare providers to ensure patient safety and care for all Mississippians.

The mission of DEA's Office of Diversion Control is to prevent, detect, and investigate the diversion of controlled pharmaceuticals from legitimate sources, while ensuring an adequate and uninterrupted supply for legitimate medical, commercial, and scientific needs. In Mississippi, the staff in this office handles the entire state in regards to the diversion of illegal drugs. Many problems associated with drug abuse are the result of legitimately made controlled substances — including prescription drugs — being diverted from their lawful purpose into illicit drug traffic.

The Office of Diversion Control consists of diversion investigators, special agents, chemists, pharmacologists, program analysts, and others. And, while it is an agency of federal oversight, there is a lot of common ground in its purpose with state agencies. Many of the narcotics, depressants, and stimulants manufactured for legitimate medical use are subject to abuse and have, therefore, been brought under legal control. Under federal law, all businesses that import, export, manufacture, or distribute controlled substances; all health professionals licensed to dispense, administer, or prescribe them; and all pharmacies authorized to fill prescriptions must register with the DEA. Registrants must comply with regulatory requirements relating to drug security and record keeping.

Diversion investigations involve, but are not limited to, physicians who sell prescriptions to drug dealers or abusers; pharmacists who falsify records and subsequently sell the drugs; employees who steal from inventory and falsify orders to cover illicit sales; prescription forgers; and individuals who commit armed robbery of pharmacies and drug distributors.

The vast majority of the healthcare providers registered for a DEA license in Mississippi is doing fine, according to Louis A. Lejarza, Senior Diversion Investigator with the New Orleans Divisional Office, but there are two groups that regularly cause frustration for him and his staff.

The first of these two groups are those providers that do not have malicious intent. These are those physicians or nurse practitioners that simply do not pay attention to what they are doing or may not be fully aware of the requirements when prescribing controlled medications for patients.

"These physicians are the ones that will write a prescription for the same amount of painkillers for a gunshot victim and a teenager with a broken arm – not realizing that this could possibly lead to an addiction for the teenager," Investigator Lejarza said.

The physicians categorized in this first group are the ones that may overlook the reality that controlled substances are a major concern and can lead to an abuse problem. They have routinely written prescriptions for years and are just doing what they have always done without thinking about the potential consequences. They habitually write the same medications and dosages rather than basing their pain medication decisions on the needs of the individual patient.

"The biggest mistake that a registrant in this first group can make when it comes to their DEA number is to become desensitized to the dangers of prescription narcotics, specifically opiates," Brown said. "We want to encourage the practitioners to remember the danger of this stuff and to just be sensible when prescribing. Use a common sense approach. Think through how the drug and the amount you are prescribing could affect your patient. Do not become complacent by not recognizing every day what you and your patients are dealing with."

The practitioner needs to realize that the lack of due diligence and caution is breeding many of the addicts that will eventually move toward the direction of the criminal drug dealer. A patient that is overprescribed and becomes addicted will turn to the illegal drug market when his physician will no longer feed his addiction.

"We want to encourage physicians to communicate with their patients and their patients' families to tell them the dangers of these drugs," Brown said. "Make your patients aware of the risks of narcotics."

The second group of concern for Brown and Lejarza is the registrants that have criminal intent and are maliciously abusing the system in the dispensing of drugs. They are those in the medical field that wish to profit from the diversion of prescription drugs and are willing to steal or forge prescriptions. This group may consist of licensed medical professionals, such as nurses, or even physicians or non-licensed staff, such as clerks and other support personnel.

"Unfortunately, the results of the two groups are the same," Brown said. "For the physician that is asleep at the wheel and writing prescriptions exactly as he always has, there is no way to predict which of his patients will have an addictive personality. With really powerful opiates, it doesn't take much; and, whether you create an addiction in someone or whether you sell illicit drugs for profit, the same statute is used to charge people with criminal intent."

A bit of advice offered by Lejarza is for physicians to be aware of the public's respect of the medical profession and to be aware of the responsibilities that come with it. A practitioner does not always understand that he is at risk.

"The health of the patient doesn't always equate to what the patients wants," he said. "The physician should give the patient what he or she needs, but not more. The physician should pay attention to his feelings and, more importantly, to his instincts. People have blind faith in their physicians and will do what the physician wants them to do. It is the physician's responsibility to control the situation."

That is where Brown believes that better education of the registrant population is advantageous. One example of this is the necessity for the intensive record keeping the DEA requires.

"We understand that a lot of our registrants get frustrated with the amount of record keeping that we require," Lejarza said. "But, this helps us to monitor trends, review their community, and notice discrepancies quickly."

Through the record keeping process and the data resulting from this record keeping process, the DEA gains knowledge of potential diversion. The DEA has a database that tracks every step in the process of drug production – from the raw materials to the distribution methods. With properly maintained records, the DEA can identify diversion of drugs more when red flags and situations where something just does not seem right are identified.

As part of the record keeping process, registrants must demonstrate that they have a valid patient relationship that justifies the necessity of the drug given. If a physician prescribes a medication, documentation of the need for that prescription is imperative. Healthcare providers need to show that due diligence was used and the drug was given for a valid medical reason. They must also be familiar with and follow the rules and regulations of the Mississippi Board of Medical Licensure.

THE ULTIMATE GOAL FOR EVERYONE IS TO PREVENT PEOPLE FROM DYING – PRESCRIPTION DRUGS KILL MORE THAN ILLICIT DRUGS.

According to Lejarza, there are two parts to a legitimate prescription. It must be issued in the usual course of professional practice and it must have a documented, legitimate medical need.

"The DEA wants to see that a registrant has done everything possible, such as physical therapy, prior to a controlled substance being prescribed for a chronic problem. A physician needs to prove a medical purpose," Lejarza said. "The DEA is not 'anti-pain' treatment. The DEA is anti-treating every patient the same and writing large numbers of opiates each month unnecessarily."

Prescription Monitoring Program

The documentation of the medical care of the patient is important; and, it must include evidence that the physician exercised all due diligence before writing the prescription. One method to prove this due diligence is the use of the Prescription Monitoring Program (PMP). Obtaining a thorough history and utilizing the PMP prior to prescribing a controlled substance are two things physicians can do which will make an immediate positive impact in their patient care.

"Mississippi is fortunate to have the PMP and to have it as a resource for the medical community," Brown said. "While it is not foolproof, if physicians will use the PMP, it will help eliminate a lot of the doctor shopping that happens."

The physicians can use the PMP for several primary purposes: 1) to determine if their patient has received controlled medications from other providers recently, 2) to review the individual physician's prescribing history and identify if his DEA number has been stolen and used in a forgery, and 3) to confirm that their patients are taking the medications prescribed for them.

Continued on page 10

Reminders for your daily practice when prescribing or issuing narcotics

All prescriptions need to have complete information, including patient name, date of birth, patient and practitioner addresses, full prescription information, and physician's manual signature. A prescription for a controlled substance must be dated and signed on the date when issued. *Title 21 CFR §1306.05 (a) - Manner of issuance of prescriptions.*

Physicians that are writing prescriptions for employees, friends, or relatives must create a patient chart to support the need for the prescription. A valid doctor/patient relationship must be established and documented in the chart. To prescribe for anyone without proper documentation fails to support the prescribing of controlled substances. *Title 21 CFR §1306.04 (a) Purpose of issue of prescription.*

It is against a federal law to turn a blind eye to known prescription drug diversion and you will be held accountable. This applies to the physician, the clinic administrator, and every member of the clinic staff. *Title 21 CFR §1301.91 Employee responsibility to report drug diversion.*

The physician's registered location(s) with the DEA must be updated if there is any change. Any location or satellite clinic where any controlled substance is stored, administered, or dispensed, including samples, must be registered separately. If a practitioner will only be prescribing from another location(s) situated within the same state, then an additional registration is not necessary. *Title 21 CFR §1301.12 (a) - Separate registrations for separate locations/ Title 21 CFR §1301.51 Modification in registration.*

If dispensing scheduled drugs as samples, there must be full and complete documentation in the patient record and in a log book. *Title 21 CFR §1304.21 General requirements for continuing records.*

Prescriptions provided by fax are NOT the same as e-prescribing. Fax prescriptions can still be forged and manipulated much easier than electronic prescriptions. Physicians need to be conscious of where the prescription goes and how it is transmitted. Sch. II prescriptions may not be filled through a faxed prescription – original prescription only – except in emergency situations. *Title 21 CFR §1306.11 (a) & (d) Requirement of prescription.*

Suboxone can only be prescribed (for the treatment of addiction) by an MD or a DO after they have been certified by CSAT/SAMSHA and then DEA has issued the practitioner an identification number attached to the original DEA registration. All appropriately licensed healthcare providers can prescribe Suboxone for the treatment of pain but, you must specify "for pain" on the prescription. *Title 21 CFR §1301.28 - Exemption from separate registration for practitioners dispensing or prescribing Schedule III, IV, or V narcotic controlled drugs approved by the Food and Drug Administration specifically for use in maintenance or detoxification treatment.*

Stock bottles of narcotics cannot be taken out of the clinic, e.g. to a physician's home, unless it is a DEA registered location which DEA has the authority to inspect. Any transfer of drugs must be made only to another registered location with appropriate documentation specifying the transfer – DEA 222 or invoices. *Title 21 CFR §1301.12 (a) - Separate registrations for separate locations/ Title 21 Section 1301.71 Security requirements generally/Title 21 CFR §1304.21 General requirements for continuing records.*

When pills in a stock bottle are divided out among clinic providers for dispensing, there must be a tracking system for each pill. The ordering physician is still ultimately responsible for all pills in the stock bottle. Drugs should not be withdrawn from stock bottles until needed and then documented immediately. *Title 21 CFR §1304.21 General requirements for continuing records.*

Do not list every DEA number associated with your clinic on a prescription. Listing the DEA number for yourself and every one of your partners is the same as handing everyone's DEA numbers to a forger on a silver platter.

Prescriptions forgers are smart and are more likely to try to forge prescriptions using the names and DEA numbers of specialists with high opiate prescribers, such as oncologists and orthopedists. "A physician in a specialty that frequently prescribes painkillers and narcotics is more at risk for forgery," Brown said. "It would be obvious if a registrant in a low prescribing specialty started writing a lot of prescriptions for opiates, but not so obvious if it is a physician in a specialty that regularly prescribes pain medicine."

Scott Hambleton, MD

Another reason to check the PMP is to be sure that a physician is not being confused with another physician and prescriptions are being attributed to the wrong registrant. This is especially important with physicians that have common names or family connections in the medical field.

The most critical issue for the DEA in regards to the diversion of prescription drugs is the increase in the number of opiate prescriptions being written. This concerns Brown. "Mississippi is not a very populous state," he said. "The raw [high] numbers of opiates being generated and prescribed is a crisis. An opiate addiction is hard to beat. As a society, we are not being careful enough with dangerous drugs."

Another major concern is the increasing incidence of medical professionals who fall victim to substance abuse. Practitioners have a high relapse rate and are among the highest groups when it comes to relapse rates unless they participate in a program such as the Mississippi Professionals Health Program (MPHP).

Physicians who are referred to MPHP because of an addiction problem and receive advocacy are engaged in a program that represents the gold standard for management of patients with addictive disorders. After five years, over 80 percent of participants in the program are clean and sober, without a single relapse, and over 90 percent are in stable recovery and return to safe and productive medical practices.

"One of the reasons we are so successful is because we require total abstinence from all mood altering, addictive substances, including alcohol and prescription medications, except in cases of medical emergencies," Scott Hambleton, MD, Medical Director for the MPHP, said. "However, unfortunately, many physicians do not truly understand the dangers of prescribing a controlled substance to a patient with a history of addiction. The risk of relapse is minimized and in many, if not most cases, the patient will return to active addiction after exposure to these substances. The problem is that a patient with addiction has no control over the way their brains respond to these substances, once the substance crosses the blood brain barrier, which is markedly different from patients without addiction."

To decrease the likelihood of a practitioner becoming addicted, the DEA strongly encourages practitioners not to treat themselves for any condition requiring controlled substances, including pain, insomnia, fatigue, anxiety, ADD/ADHD, etc.

"So many of the registrants that have issues with the DEA are because of their own issues – either self-prescribing or prescribing for a close family member and thinking that is OK," Brown said. "And, just as the practitioner should not treat himself with controlled substances, he should avoid at all costs prescribing them for family members and friends without an appropriate medical workup and documentation."

The DEA is, first and foremost, a law enforcement agency; and, they are asking for the medical community's help. The ultimate goal for both law enforcement and medical professionals is to prevent people from dying. In recent years, prescription drugs killed more victims than illicit drugs. If a physician has a question, just make a call. Brown and Lejarza both stressed that a physician cannot overdo it by calling more than one agency. A healthcare provider should call the MSMBL or the DEA or the MBN (Mississippi Bureau of Narcotics) anytime he has a question.

"If you are not sure about something with a regulation, please call," Brown said. "If someone is using your DEA number, report it immediately. Don't hide it. Help us solve the problem. We are not out to get the ones that are doing the right thing, we are after the criminals.

DEA Contact Information

Drug Enforcement Administration
Jackson District Office
100 W. Capitol Street, Suite 1213
Jackson, Mississippi 39269

Office of Diversion Control:
Phone: (601) 965-4400
Fax: (601) 965-4401
http://www.justice.gov/dea/index.shtml

Through the DEA website, anyone can provide an anonymous tip. If you have information to share but do not wish to be identified, please go to www.deadiversion.usdoj.gov and click on the "reporting" tab. An anonymous tip can be submitted to the DEA.

Communicating Unexpected Diagnostic Results: How and Why

By Maryann Wee, RN, BSN
Director of Risk Management

At Medical Assurance Company of Mississippi, we continue to have cases that involve a breakdown in communication between the referring physician and the diagnostic specialists in pathology and/or radiology.

What we have seen in claim files is that the diagnostic specialist discovers a serious or unexpected finding and the referring physician is not called and notified of the finding. The unexpected finding is communicated as part of the report, but in such a way that does not alert the referring physician to the seriousness of the finding. As a result, the patient is never informed of the finding or may learn of it after several months have gone by. Therefore, the patient alleges that he or she was not appropriately diagnosed or treated in a timely manner, and a claim is filed.

There are usually communication breakdowns on the part of both the diagnostic specialist(s) and the referring physician(s), involving areas of verbal and written/electronic communication that can be improved.

From the View Point of the Diagnostic Specialist

Radiologists and pathologists have a duty to communicate unusual or unexpected results to the referring physician. How to communicate the results is addressed by their respective professional organizations (parameters of the American College of Radiology (ACR) and the consensus statement from the College of American Pathologists (CAP) and the Association of Directors of Anatomic and Surgical Pathology). The references for these statements and/or parameters can be found at the end of this article.

The goal for the diagnostic specialist to ensure maximum patient safety is to have direct communication to the right person, in a timely manner, and by appropriate means.

Verbal Communication

The best method to convey an urgent finding and important information is to speak directly to the referring physician. This physician-to-physician communication will serve to highlight the importance of the findings. If it is not feasible to speak directly to the referring physician, then the pertinent information can be provided to the highest level of professional available with an emphasis to that person of the importance of getting the information to the physician.

Edward L. Gieger, Jr., MD, a retired radiologist formerly in private practice in Mississippi, said if he had repeated problems getting a physician on the phone, he would make an appointment with the physician or clinic manager to discuss the physician's preferred line of communication.

"I want the physician or the clinic manager to tell me who I need to ask for when calling with an urgent or unexpected finding," Dr. Gieger said.

There are usually communication breakdowns on the part of both the diagnostic specialist(s) and the referring physician(s), involving areas of verbal and written/electronic communication that can be improved.

Referring physicians have also said that they appreciate having contact information — that is a direct extension or e-mail — of the radiologist and pathologist on the report they receive if any clarification is needed or additional questions need to be answered.

As a diagnostic specialist, if you have the ability to directly import into a referring physician's email queue, don't use this option exclusively. Inform the referring physician first and then import the document. And, when you do import the report, title it to alert the staff and physician as to its importance and that the document needs to be viewed in a short time frame.

The diagnostic specialist should document on the report or in an addendum to the report the verbal communication he had with the referring physician. Note specifically who was given the information; the time and date of the conversation; and any specific details of the discussion as are clinically appropriate.

Written Communication

As a backup to the verbal report, the written report also needs to demonstrate the importance of the findings. Important or unexpected findings should be highlighted and prominently placed in the report to the referring physician, i.e. at the top of the list of findings. To draw even further attention to the unusual findings, consider marking the information in bold in the report.

In today's world of electronic records, where healthcare providers are bombarded with data every day, it is even more important to make the critical information stand out. Unusual findings should be written in medical language that is easy to understand for physicians of all specialties, not just pathology and radiology. Remember your au-

dience. If you have recommendations, they should be clear and concise. The clinical recommendations should not be written in language to protect the radiologist or pathologist from liability, but to communicate the clinical consultation to the referring physician for the care of the patient.

If advising further testing, the recommendation should be specifically phrased in such a manner that the referring physician is clear on your expert opinion and the need for further testing, including the urgency of this testing.

Electronic Communication

The use of electronic communication — such as texting, facsimile, voice messages, instant messaging, and email — to communicate results has been addressed in the guidelines for the diagnostic specialties. To review briefly:

- The sender has no assurance that the message was received.
- Electronic communication is generally inappropriate to convey important and unusual findings.
- Electronic communication is better used as a backup system once the information has been verbally conveyed.
- Any communication method used must be in compliance with the privacy requirement of HIPAA.

Guidelines on Communication

Each pathology and radiology practice should have written policies on how to communicate urgent, significant and unexpected diagnoses to the referring physicians. This policy should be in addition to the critical values laboratory results and include, at a minimum:

- What constitutes an urgent or significant finding
- How this urgent or significant finding is to be communicated to the referring physician
- Documentation of time and date it was communicated
- Steps to take if problems occur while communicating the information
- How this communication occurred should be documented

Each practice should refer to the appropriate governing body of their specialty for guidance in writing this policy.

William A. Rock, Jr., MD, Professor Emeritus in the Department of Pathology at UMC, also had further suggestions on the importance of policies to cover communicating with a referring physician.

"The policy might include stop gap procedures such as a pop-up at the end of a dictation which asks 'Is this an unexpected result that requires immediate referring physician notification?' If yes, code yes. Then, an additional flag is added to the dictation preventing sign-out until the notification is documented with this dictated report." Dr. Rock said.

Develop a template that pops up and lists the items to be included in the notification process that must be completed before the notification can be finalized. Comments should be short, brief, and to the point with date, time, and person(s) that was contacted. It might be possible to electronically connect the physician of record for this report to that physician's preferred method of notification. The report might be placed in a pending file until notification and documentation is complete.

As reports are generated that receive this additional comment, they are 1) forwarded as per policy to the patient's physician/physician office, and 2) printed again at the end of the day in the office(s) of the person dictating the report. This may be electronic or via paper report. This latter effort will assure compliance and provide copy for periodic review for content.

From the View Point of the Referring Physician

System to Receive and Document the Findings

Develop a system in your practice as to how to receive a verbal report and communicate this information to the physician who ordered the testing. If the physician that ordered the test is unavailable, who will receive the information and be responsible for reporting it to the ordering physician? This should be the highest level of professional in office, preferably a registered nurse or licensed practical nurse, who writes down the information. Once a verbal report has been given, it is best if the written report with the findings is electronically sent afterwards. The nurse can then convey the information to the referring physician in both verbal and written form.

To avoid delay, include in the notification system steps to take in the event that the ordering physician is not available. The system should address contacting a covering physician if the referring physician is out of office for an extended length of time. Be prepared for the danger times of weekends and holidays when communication can be delayed.

As always, the best system and policy is a physician talking to another physician. If you are the referring physician and have questions, call the radiologist or the pathologist to get clarifications and details so you can talk with your patient and give details and formulate a better clinical care plan. Be prepared to answer the questions that your patient may have.

Documenting the Communication

As the referring physician, you should document who called you — the radiologist and/or the pathologist — and the time and date of the communication and what was told to you about the findings. If possible, ask that a copy of the report be sent electronically as soon as possible to verify the findings.

Fail-safe System to Get Results to Patient

So, now you have the results in hand. You have communicated verbally with the diagnostic specialist and received a written follow-up communication and you understand the urgency of the findings.

Communicate immediately to the patient via the telephone and make an appointment to see them and discuss the findings. It is best to give bad news in person where you can gauge the reaction of the patient and further explain the situation. But, if it is not possible to communicate in person, you can discuss the findings over the telephone so as not to delay further testing or care. Give the patient a care plan and emphasize the need to follow through for their health. Again, document all this information in the medical record. Avoid using a letter to convey this information, unless it is as a last resort and due to an inability to reach the patient. If you must use a letter, it should be sent certified mail with a return receipt, as well as regular mail. Remember to document in the medical record all attempts and the actual communication with the patient.

Place the patient in a follow-up system

Make sure patient follows through with planned testing or referrals. If the patient does not keep those appointments, call the patient. It is better if the physician (not his office staff) makes the call and explains to the patient why they should have the follow up testing or see the referred physician. This communication coming from you as a physician carries more weight with patients.

There are also certain guidelines that mandate a direct communication with a patient by a diagnostic specialist, such as a radiologist communicating the results of a mammogram. In these situations, the diagnostic physician should either dictate an appropriate letter to the patient or, if he uses a template letter, be sure that it properly conveys the message using straightforward, clear, non-medical terminology on a fifth grade reading level.

In Summary

"Patients get better care when physicians communicate," Gerry Ann Houston, MD, MACM Medical Director, said. "The radiologist and/or pathologist must call the referring physician with any significant findings and the referring physician must be available to take the call. The two can then plan the next step to appropriately care for the patient."

In this supposed age of communication, it sometimes seems to be more difficult to communicate important information to an individual. The findings of unexpected or serious problems by a radiologist and/or a pathologist need to be communicated to the referring physician and patient in a well thought out manner and with a fail-safe system in place. With careful planning and cooperation by both the diagnostic and treating physicians, this can be accomplished, and delays and overlooked diagnoses can be avoided.

Although this article centers on radiologists and pathologists, these specialists are not alone in the need to communicate unexpected results. Below are instances from a few other specialties with examples of conditions that may require notifications of the referring physician:

Cardiologist:
- EKG - Transesophageal echo indicative of serious disease, MI, atrial appendage clots

Neurologist:
- CNS studies - muscle findings of a life threatening nature

Gastroenterologist:
- Endoscopies – finding of potential tumor

Clinical Pathologist:
- Protein electrophoresis with evidence of multiple myeloma
- Cerebrospinal fluid evidence of multiple sclerosis
- Positive cystic fibrosis findings

All specialties:
- Samples sent to a reference lab. Is a report received? Does the physician see it? Is it entered into patient's chart?

References

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2013: Risk Management Analysis of Claims Committee Files

By Beth Easley, RHIA
Senior Risk Management Consultant

Every month, the MACM Claims Department prepares an agenda of files for review by one of the two physician-membered Claims Committees. During the Claims Committee meeting, a physician who belongs to the same specialty as the defendant physician, or is otherwise familiar with the applicable standard of care, thoroughly reviews the case and informs the committee members of clinical concerns. But, prior to, during, and after this monthly meeting, staff from the Risk Management Department review these same claims and questions in order to monitor the risk management issues associated with the cases.

Each claim from the monthly Claims Committee meeting is reviewed, and by the end of the year, the Risk Management staff has collected cumulative information identifying trends and issues. The purpose of this review is to identify risk management issues that contributed to the claim and/or defensibility of the claim.

We currently have 18 years of data on file which include 1,261 cases to consider and from which to draw conclusions. With this data, we have been able to analyze trends from the perspective of risk management to see how we, as a department, can work with our insureds to prevent and/or mitigate future lawsuits.

The cases reviewed in 2013 did not feature any dramatic differences from the trends that we have seen before, but we believe that regularly offering our findings to insureds is a part of our responsibilities as the Risk Management Department and hope that this information will prove beneficial to you in your daily practice.

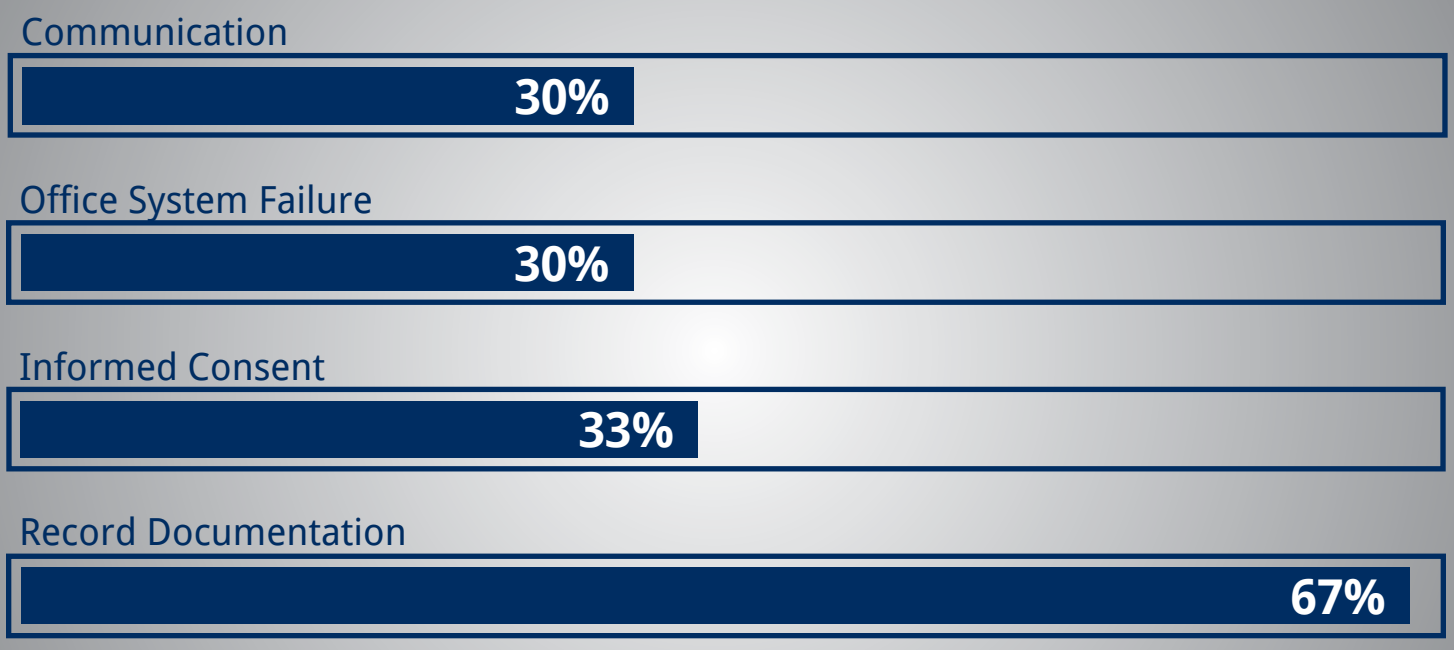
Average Claimant and Location:

In 2013, there were no drastic changes regarding the characteristics of a typical claimant, which continues to be a middle-age female with private insurance.

Also, in 2013, there was very little change in the setting where the incidents occurred. The majority of incidents continue to be in an inpatient environment (53 percent) as opposed to an outpatient setting. This has been the trend for the last five years.

As is done each year, the concerns identified in each case files are categorized into three areas for analysis – Risk Management Issues, Clinical Issues, and Other. Of the 43 cases that were reviewed during 2013, 70 percent had a risk management issue, which could have included medical record documentation, communication issues, of-

Risk Management Issues of 43 Files Reviewed in 2013



* Please note that one file could be designated with multiple issues.

fice system failures, and informed consent. In these same files, a clinical issue was noted 67 percent of the time and an "other" issue was seen in 81 percent of these same files. Please note that the majority of files reviewed could have had multiple issues.

Clinical Issues:

In 2013, the instances of clinical issues increased and within those clinical issues, the majority of the cases saw an issue involving a practice-related concern as opposed to a diagnosis-related concern. The allegations that were generated as a result of a diagnosis were both in 1) delay of diagnosis and 2) delay in obtaining a referral in a timely manner. Many of the delay in diagnosis allegations were related to a lag in diagnosing post-op complications, such as a bowel perforation after a gynecological procedure. There were several incidents where the patient was not timely referred to a larger center for more specialized treatment.

Risk Management Issues:

Within the issues attributed to risk management failures in those 43 cases, 30 percent had a communication issue that was a result of a breakdown in communication between providers. The majority of these miscommunications and/or failures to communicate were between physicians, with the most dangerous times being handoffs between on calls. Failure of communication between physicians and nurses was the next largest category.

Documentation issues that were seen in 2013 centered on poor documentation of the plan of care in the office and in the hospital and the rationale behind the course of treatment. Legibility continues to be a major problem in written (non-EMR) charts. Timeliness in dictation of operative and procedure reports was a concern, especially if the report was dictated after an unexpected death or bad outcome.

Informed consent issues fell in 2013 to 30 percent when compared to an average of 41 percent in years prior. The problems arise when an informed consent form is missing elements (usually conditions specific to the patient's medical condition) or the consent form is not completed. The use of a generic hospital consent that was not specific to the procedure was also a concern.

Office system failures also contributed to 30 percent of the cases in 2013. The major concern was with the triage and documentation of telephone calls. The next biggest area of concern was failure to follow-up on high risk patients who had missed appointments and follow-up on critical or unexpected diagnostic testing.

In addition to office-based issues, 2013 saw hospital system failures as well. In what may be a reflection of dwindling resources in the hospital setting, the main concern was an alleged lack of monitoring by the staff nurses of a patient whose medical condition worsened.

Everything else:

And again in 2013, there was an assortment of "other" issues that were noted in the case files.

These "other" contributing factors included another provider's malpractice that contributed to our insured being involved in litigation, and patient concerns such as substance abuse or failure to comply with treatment. Another factor in the claims files was if the patient had a family member who is involved in a healthcare field. This may attribute to higher awareness of the healthcare system and more knowledge when things go wrong. There are still instances of jousting (making offhanded or ill-informed comments verbally or in writing) among providers.

So, what do you as a MACM insured need to do with this information? What difference does it make to you?

First of all, we hope that you will review this information and see if you recognize yourself in any of these issues or conditions that caused a lawsuit to be studied. If so, then give us a call and let us come and help you with that situation. If not, then realize that your Risk Management Department will continue to follow and trend data retrieved from analyzing claims presented to the Claims Committees and provide that information to you. We believe it gives our staff areas of focus to continue to monitor and evaluate.

By referencing the allegations of these claims, we are not stating that the allegations are true. We are only providing the allegations in order to show what the plaintiffs claimed, which were generally unsupported as shown by the defense verdicts.

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2014 Office Staff Program Concludes with Much Success

By Kathy Stone, RN
Senior Risk Management Consultant

"I don't know if you can help me; but…" This is the way many phone conversations (and even emails) begin when our physicians and their clinic staff contact us on virtually a daily basis. As a matter of fact, in 2013 the Risk Management Department received over 1,600 such inquiries. Some of the questions can be answered by the consultant immediately, while others may require a team approach and time to research the issue.

The team may include some or all of the risk management consultants as well as our legal counsel and medical director. This approach to our insureds' questions results in what we believe is the best possible answer or recommendation for each unique situation.

When planning for the 2014 Office Staff Program (OSP), it was decided we would present information related to the most common and difficult questions we receive. We wanted to provide the same level of information in our OSP as we would to individual callers. Therefore, we developed the OSP to share information from both a legal as well as medical perspective.

The purpose of the 2014 OSP was to provide guidance on common issues for which there is very little public information available to our clinics, such as the use of the Prescription Monitoring Program. Additionally, the issues surrounding the ongoing medical management of noncompliant and disruptive patients and proper withdrawal from care were addressed in detail.

The 2014 OSP was presented 12 times in 11 different locations across Mississippi. Over 425 attendees have been educated this year through these presentations.

If we presented the program in your area and you missed it, we will be glad to schedule a presentation of the program to your clinic as our other duties will allow us.

In Memoriam

On April 28, 2014, Medical Assurance Company of Mississippi lost a member of its work family when Sharon Pell was killed in the tornado that came through Richland, Mississippi. Sharon had worked for MACM for 26 years, most recently serving as Senior Administrative Assistant in the Risk Management Department.

Sharon is greatly missed by everyone at MACM and by those that she worked with as part of her responsibilities here. We will continue to remember her family during this time.