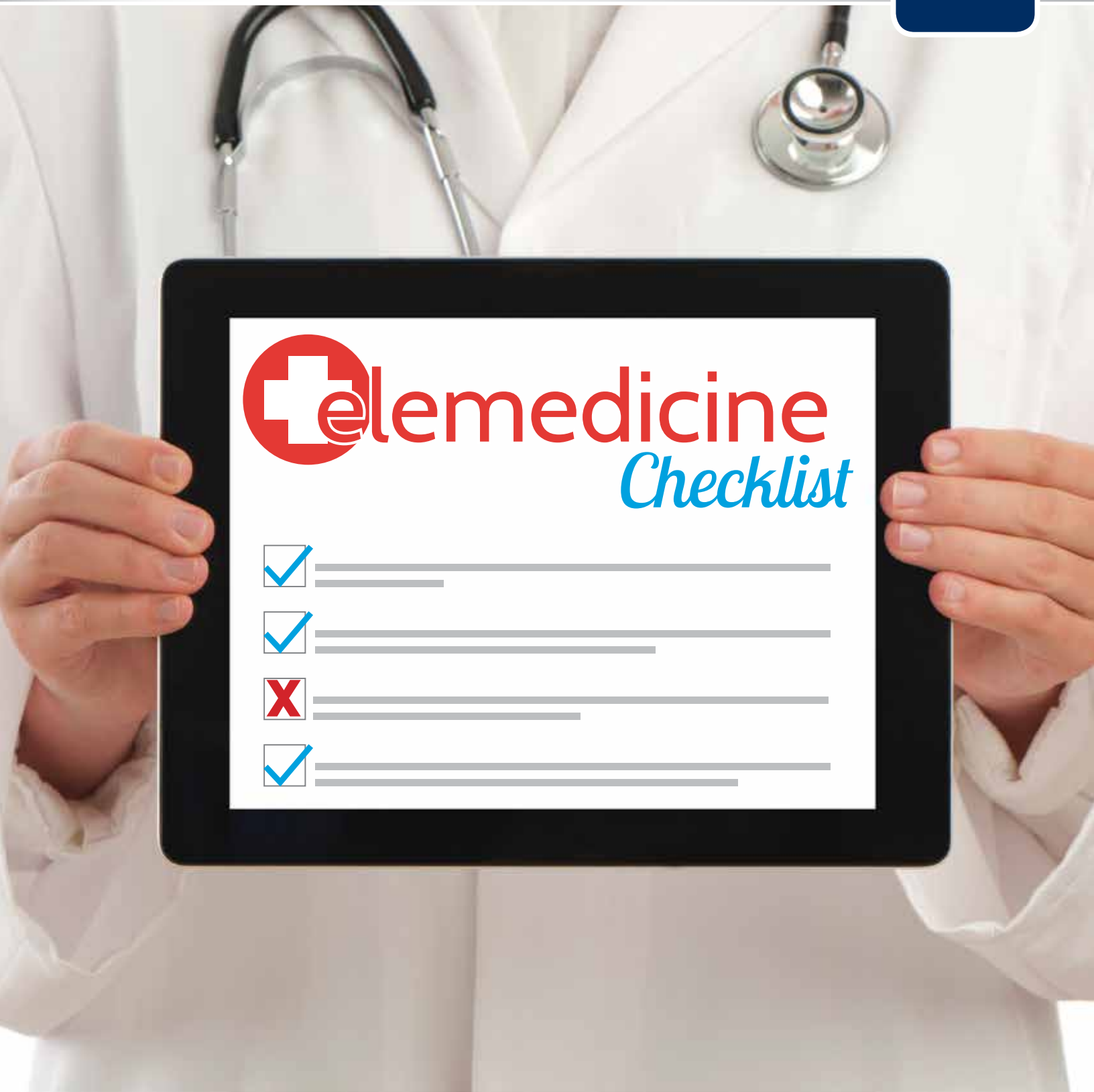
Medical Assurance Company of Mississippi

Risk Manager

Considering telemedicine for your practice? Check out this issue's cover story and check list.

Fall 2015



Dear MACM Insured:

Welcome to the latest issue of the MACM Risk Manager! So much is going on in medicine right now, and 2015 has been a very busy year for the staff of the MACM Risk Management Department. We have networked, researched, and educated ourselves throughout the year to keep ourselves up to date on current issues that impact your practice.

Telemedicine continues to be a regular topic of discussion in our offices. Please know our staff attends meetings of the Mississippi Board of Medical Licensure and will communicate with you any decisions or changes regarding the use of telemedicine in the practice of medicine. Kathy Stone, Assistant Director of Risk Management, is heading up our telemedicine team and has provided a "checklist" in this issue. If you are considering incorporating telemedicine into your practice, take a look at this checklist for some things to contemplate.

Telemedicine was the subject of the first-ever MACM webinar on July 30, and we are proud to say the webinar was a huge success! If you did not have a chance to listen "live" to the webinar, we have included information about how to access it "on-demand". I think you will find listening to the webinar will be time well spent.

Another area of importance to us is the collaborative relationship between physicians and nurse practitioners. Through relationship building with the Mississippi Board of Nursing and the Mississippi Nurses' Association, we want to work with these providers and develop risk management efforts to benefit our insured physicians and the nurse practitioners that they employ and with whom they collaborate.

In September, our biannual CME program was held in New Orleans. MACM insureds, clinic representatives, and staff spent two days learning and networking in the Big Easy. Included in this issue is a synopsis of the presentations that were delivered by our nationally recognized speakers. I hope this will give you a taste of what we heard in New Orleans.

And, finally, I want to welcome to our staff Michelle Burns, RN, MSN, the latest addition to our Risk Management team. Michelle comes from a background of educating physicians, and I hope you will have the chance to meet and work with her soon.

Your Risk Management staff is busy and working for you. We plan to continue to stay up-to-date on the issues affecting our insureds. As always, if there is any way that anyone in Risk Management can assist you, do not hesitate to let us know.

Sincerely,

Maryann Wee, RN, BSN
Vice President of Risk Management

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Houston's Handoffs

Gerry Ann Houston, MD - Medical Director

One of the new buzzwords is that of "handoffs" (hence, **Houston's Handoffs**). In football, this is the act of handing the ball to a teammate. In the medical world, the act is similar though it is handing off the care of a patient from one provider to another. Nurses have been doing it for years at shift change, at transfer to and from an intensive care unit, or at discharge to another facility or the patient's home. And when I was a resident, we had daily sign out rounds to ensure the patients the residents cared for during the day were appropriately cared for at night.

With more hospitalists caring for patients and fewer physicians admitting and following their "own" patients in the hospital, there are more and more opportunities for handoffs and, as a result, more opportunities for errors or mishandling of the transfer. These handoffs may occur at the time of admission when care is transferred from the primary physician to the hospitalist or when the patient is sent back to the primary physician at the time of discharge. And handoffs occur during the admission as one hospitalist ends his shift and another one begins his.

A Joint Commission evaluation of root cause analysis reveals that almost 70 percent of sentinel events are caused by communication problems with at least half of these occurring during handoffs. Communication in the good ole days was mainly via the chart, the telephone, or face-to-face. Now text, facsimile, email, video, and electronic medical record have to be added to this list of communication devices. So with more vehicles of communication come more chances of error during a handoff. The electronic medical record has been touted as improving patient safety and cutting down on errors. That is not always the case as seen in this example:

A 99-year-old lady with Alzheimer's dementia in the nursing home was admitted to the hospital with fever and SOB. Chest x-ray showed a pneumonia that was felt most likely to be aspiration. She was treated with appropriate antibiotics and had a modified barium swallow done. As expected, she aspirated during the swallow and was made NPO. Her family elected no artificial nutrition, and due to her advanced dementia, she was referred to inpatient hospice. The hospitalist, who discharged the patient on the weekend and who was not the one who cared for the patient the previous week, did an electronic med reconciliation as required and continued her PO meds after discharge. Before transfer of the patient, the hospital nurse "handed off" the patient to the hospice nurse with a phone call and reported she was NPO. However, when the patient arrived at hospice, the med rec accompanying her listed multiple PO meds for her to continue. The discrepancy was identified, and her oral meds were discontinued at hospice.

As illustrated, errors in communication were made when this patient was discharged. Fortunately, there was no injury to the patient, and no sentinel event occurred. In addition to the problem of incorrect information being given in a handoff, necessary handoffs often times just do not take place. Patients discharged to other facilities may arrive without any prior communications from the transferring institution.

Patients being discharged to their home have many more potential problems from handoffs or lack of them. Many patients who are discharged home are not given clear instructions, do not know when follow up appointments are scheduled, and may be unaware that test results are pending. Patients must be given a simple list of home medications to continue or discontinue. For new medications, patients need to know if the prescription will be faxed to their pharmacy or whether they need a hard copy to take themselves. Potential side effects from the new medications must be explained to the patient and family if the patient is not able to comprehend.

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telemedicine Checklist

HOW TO GET STARTED

Kathy Stone, RN, BSN
Assistant Director of Risk Management

In recent years, there has been tremendous growth in telemedicine, ranging from online consultations with patients to a breakthrough system that links remote monitoring of vital signs (such as temperature and blood pressure). As the use of these technologies expands to increase access to care, the risk of liability for our insureds likewise expands.

When considering the use of telemedicine in your practice, consider the following to improve your liability risks.

1. **Review the Mississippi State Board of Medical Licensure Telemedicine Regulations (and Mississippi Board of Nursing Regulations, if working with APRNs).**
2. **Decide on the following:**
    a. Type of service you want to provide,
    b. Locations of service – at both ends,
    c. Telemedicine practice times (how many hours each day and how many days each week),
    d. Personnel needed – at all sites.
3. **Choose appropriate technology to accomplish your plan.**
    a. View several options.
    b. Discuss with other providers using same technology.
    c. Make site visits to see technology in action.
4. **Review all contracts thoroughly. Look for the following:**
    a. Who will "own" the medical records?
    b. Will the records be easily accessible at both sites?
    c. Is there an indemnity clause?
    d. What assurances are made by vendor regarding maintenance and problem solving?
    e. Have a healthcare attorney review the contract before you sign it.
5. **Ensure privacy protection of all medical information and related data.**
    a. This should be addressed in contract.
    b. Must apply to both the use of the technology and the medical records generated.
    c. Is transmitted data encrypted or otherwise protected?
    d. Will vendor be responsible for privacy and security of system?
6. **Train all staff involved – at all sites.**
    a. Include clinicians and support staff in training – **everyone** who will be involved in the telemedicine process.
    b. Document all training, including who was present and the content covered.
    c. Document dates of both training and re-training that occurs after the program is running.

7. **Set up policies and procedures for telemedicine practice, including:**
    a. Need a policy for HIPAA compliance,
    b. Criteria for patient selection,
    c. Process for managing urgent/emergent situations identified during a telemedicine encounter,
    d. Share all policies and procedures with staff at all sites.
8. **Determine how you will decide which patients to see via telemedicine. Consider the following when deciding who you want to treat:**
    a. Established patients only or new patients?
    b. Patients established only with you or also with your partners?
    c. Follow-up visits only or new onset problems too?
    d. Follow-up only on certain diagnoses, *e.g.* DM, HTN, ADHD, etc.?
    e. No telemedicine for certain complaints, for instance, those that may require urgent care, a hands-on exam, or further diagnostic studies unavailable via a telemedicine visit. Be specific with a list of diagnoses you will not treat via telemedicine.
    f. For new patients, what types of complaints or issues will you see in telemedicine?
    g. Any age limits on patients? Are any too young or too old to be seen via telemedicine?
    h. Location of patient? Limited to a structured environment, such as another clinic, or will you see patient in her home or even if she is on vacation?
9. **Refuse to provide care if technology is not working properly or patient's condition is not suitable for telemedicine.**
10. **Have a plan to transition visits from telemedicine to in-person.**
11. **If patient refuses, document refusal for transition to in-person visit.**
12. **Document a telemedicine encounter to the same extent that an in-person visit would be documented.**
13. **Be sure all paperwork completed at remote site is entered into medical records and practice administration files.**
14. **Obtain informed consent from patient for a telemedicine visit using a consent form which includes the following info:**
    a. Basic explanation of how the telemedicine encounter will be performed,
    b. ID of patient, provider, and provider's credentials,
    c. Provider will determine if patient's condition is appropriate for telemedicine visit,
    d. Details on security measures taken,
    e. Possibility of loss of information due to technology failures,
    f. Assurance of availability of appropriate follow-up care,
    g. Complete medical record will be maintained and available to patient per usual request procedures,
    h. Limitations of telemedicine, as well as risks and benefits,
    i. How patients can access care in the event of an adverse response to treatment or failure of the technology or equipment.
15. **Patients must still sign the usual forms for consent to treat, privacy, and release of information.**

This checklist is for informational purposes only and is in no way intended to amount to a representation regarding insurance coverage. Further, it is not intended and should not be construed to be or to establish the standard of care applicable to physicians practicing in Mississippi. This information should not be regarded as legal advice. We encourage physicians to seek the advice of their own legal counsel. Finally, this list is not exhaustive, and there may be additional areas which require your consideration prior to beginning a telemedicine practice.

Left to right
Terri Pounders, CFNP; Shane Scott, DO; Eric D. Harding, MD; Leanne Lewis, FNP-C

INTERNAL MEDICINE & PEDIATRIC CLINIC OF NEW ALBANY:

WORKING AS A TEAM FOR BETTER PATIENT CARE

Open communication and a team-based approach to the practice of medicine are just a couple of the reasons behind the successful relationship between physicians and nurse practitioners at Internal Medicine and Pediatric Clinic (IMPC) in New Albany and, ultimately, the success of the clinic.

For MACM insureds Eric Harding, MD, and Shane Scott, DO, the two nurse practitioners at IMPC serve as an extension of what they as physicians can offer patients by mirroring their practice patterns and philosophy. At the same time, the nurse practitioners make access to good medical care available to more patients, who know they are being seen by someone their doctor trusts.

"We all practice medicine to the latest standards and not on an emotional whim. The nurse practitioners are empowered and have the full medical record in front of them when they are interacting with a patient. They understand medicine, and they know what they are doing," Dr. Scott said. "Our nurse practitioners have the same practice patterns as Dr. Harding and me. There is not a weak link. The patient knows that no matter who they see in the clinic, the message will be the same."

Terri Pounders, CFNP, finished at Mississippi State University in 1995 with an interest in a future medical career but had never heard of a nurse practitioner. It wasn't until she became ill and cared for by a nurse practitioner who lived nearby that she became interested in this level of nursing practice. Pounders went to Vanderbilt University in Nashville and completed a master's degree, specializing as a neonatal nurse practitioner, but didn't want to stay in a big city. She felt called closer to home in New Albany where she could get a post-master's certificate in family medicine at the Mississippi University for Women. She began work at IMPC in December of 2010.

Leanne Lewis, FNP-C, graduated from the University of Mississippi Medical Center with a dental hygiene degree. Her husband is a minister and moving from church to church regularly is part of his profession. For Lewis, it was hard to establish a practice as a dental hygienist with the possibility of moving always in the future. But, she still wanted to work and contribute to their family, and her practice as a nurse practitioner at IMPC allows her to do just that. Lewis received her master's degree as a family medicine

nurse practitioner from the University of Alabama at Birmingham in December 2011 and started work at the clinic in February 2012.

Both physicians at IMPC start the day with a full schedule and usually see around 30 patients per day, but both nurse practitioners are scheduled with openings on purpose for flexibility so that walk-in patients are seen as needed throughout the day. Depending on the time of year, the nurse practitioners will treat up to 20 patients per day.

Collaboration and Communication at IMPC

For most of the governing medical boards in Mississippi, collaboration is defined as an advanced practice registered nurse working within a consultative relationship and established practice guidelines. At IMPC, collaboration means open communication in which decisions are made to provide the best patient care. As required, the physicians do sign off on patient charts to ensure proper decisions were made in providing patient care, but they are also available and communicate with the nurse practitioners and other staff every day.

"We talk. We ask questions of each other, and we work together," Dr. Scott said. "We don't tell Terri and Leanne what to do. Both know their limits and understand their boundaries, and both will ask when they need help. It just makes for good patient care for us to empower them to do their job and then stay out of the way until they need us."

The physical layout of the clinic is designed purposefully to allow one physician and one nurse practitioner to share space and work next to each other in an area known by the staff as a "ledge". The other physician and nurse practitioner share another ledge less than 20 feet away with all four working in close proximity to one another.

"By working side by side, it opens the flow of conversation," Dr. Harding said. "Our nurse practitioners do not have to check in with us on every patient, but we are right there beside them if they have a question. Most of our patients have been seen by each provider in the clinic. This team approach of working together ultimately benefits our patients."

The adaptation and availability of electronic medical records at IMPC has also made it easier to communicate among the providers and can be counted as another contribution to the success of the physician and nurse practitioner working relationship. But, for some, the EMR is a love-hate relationship.

"I love it, but I hate it when the electricity goes out or when there are technical issues," Pounders said with a laugh. "We use EMR for everything – charting, vitals, history, messages back and forth – any interaction with the patient or decision reached is documented. We add a lot to our EMR and can customize it for the needs of our clinic. We don't just check a box."

Through the use of a "tag" system in the clinic's EMR, both Dr. Harding and Dr. Scott can be kept informed as they review charts and can be as involved with every patient as need be. This tag system also informs them of every patient that has been seen in the clinic on any day.

"We see more of the chronic patients and are responsible for their care management. But, if there is a change in a patient or if we have a question, we are going to ask Dr. Harding or Dr. Scott because they know the history of the patient," Pounders said. "We are a small town practice. Our doctors have practiced here for so long and are such a part of the community — they know people and they know connections. Regularly, our conversations begin with 'do you know?'"

Of note when working with Nurse Practitioners:

- Close collaboration and regular communication between advanced practice nurses and physicians enhance patient care and build trust.
- Advanced practice nurses can provide excellent care to patients, especially the chronically ill, since they are skilled in patient education and can usually spend more time with each patient.
- Physicians and APRNs can work together to ensure that patients are seen in a timely manner without long wait times for appointments.
- Before employing or collaborating with an APRN, the physician should identify the goals for the relationship – what does the physician hope to accomplish by working with a nurse practitioner?

Educating and Advising – Patients and Each Other

In addition to advice and counsel regarding treatment plans, another benefit of the daily accessibility to the physicians is a growth of knowledge base for the entire staff. Dr. Harding and Dr. Scott encourage an atmosphere of open communication and encourage their staff to ask questions by providing an environment of learning – both verbal and hands-on.

"If we have a question, our doctors will answer the question and then will explain the reasons why. They explain the physiology. It is a great learning environment, and the explanation always makes the answer easier to remember. Our doctors have a very patient spirit that can tolerate a lot of multitasking and a lot of stressors," Lewis said with a laugh.

The two physicians review charts routinely as part of the collaboration process. Above that, all of the providers meet as a group regularly to discuss patient charts by asking questions and talking about the process involved in the decision-making.

Not only do the nurse practitioners often look for subjects to learn about that would benefit their practice, but the entire staff at IMPC is encouraged to continually learn and grow in their knowledge base. The physicians stay current on recommendations and understand what is going on in medicine. Everyone works together to keep up-to-date on medical issues and to share the knowledge among all the staff bringing a definite peace of mind and a level of comfort to every provider that they are doing what is best for the patients.

"Everyone is doing their job to the best of their ability by providing the best care available and being accountable to each other. This way, the individual parts function as a whole," Dr. Scott said. "Everyone is practicing at the top of their licensure-level ability, has responsibility, and is empowered to make decisions."

A team-based approach to care is evident throughout IMPC. Everyone – from the front desk staff that greets the patient to the providers to the billing department – understands that they have a role to play to be sure that the clinic runs smoothly. The nursing staff is not assigned by provider; rather, everyone functions as a team by working together. While some may have responsibilities greater than others, each person working at the clinic has the same goal of providing the best possible care for patients. The end result is good patient care, and everyone pitches in where necessary.

"If I don't have a patient, I will do other things to stay busy and to keep the clinic moving," Pounders said. "If the lab gets behind, we will go and help to catch up. Sure this gives me something to keep me busy, but more importantly, by all working together, it cuts down on the wait time for our patients which makes for a better experience when they come to us."

During the past couple of years, the entire staff at IMPC has concentrated on educating the patient population about the relationship between the providers and that seeing a nurse practitioner is not a lower standard of care, but rather allows quicker access to quality care. The patients know every provider is on the same page when it comes to the delivery of care, and a physician is always available to the nurse practitioner if needed or requested by the patient.

The Benefits of a Staff Nurse Practitioner

For Drs. Harding and Scott, there are so many advantages to employing and working with a nurse practitioner. A nurse practitioner can help a physician carry the load of a practice by seeing more patients in a cost effective manner and with a quality patient experience. "A nurse practitioner does offer a cost savings to the clinic, but we are also providing proper medical care," Dr. Harding said.

Another benefit of a staff nurse practitioner is the ability to spend more time with a patient and to have the flexibility to do more counseling and teaching, if needed. At the same time, a nurse practitioner can see a patient with minor issues that might not require a physician's level of training at every appointment.

"Often times our patients will request to see Terri or Leanne," Dr. Scott said. "Our patients understand the working atmosphere we have established, and the patients know that Terri or Leanne will come get us if that is what they want."

When considering hiring a nurse practitioner, Dr. Harding suggests that a physician have very clear goals for the relationship and the medical practice and that those goals are communicated.

"We spend a lot of time in training when hiring any new employee," he said. "We want our entire office staff to understand what we mean when using the term *quality healthcare* and how that level is to be reached with our patients. Each of our employees understands the big picture of our practice and what the individual responsibilities are in the clinic."

Adding staff, including a nurse practitioner, is a business decision. But, for a clinic that finds the right person — someone that is teachable, a team player, and willing to go the extra mile — it can be a definite benefit to the practice.

Communication, collaboration, and mutual respect must coexist in order for the clinic to function properly. And, there is a definite level of trust among the providers at IMPC of New Albany. Each person knows that they are a vital part of the team. When a staff values and respects one another both inside and outside the work environment, a healthcare experience that prioritizes the patient receiving the best care possible is the ultimate result.

Michelle Burns Joins MACM
As Risk Management Consultant

The MACM Risk Management Department welcomed a new team member on August 24, 2015, when Michelle Burns, MSN, RN joined the department as a Risk Management Consultant. Through the educational services offered to insureds by the Risk Management Department, Burns will work on issues and topics that affect the delivery of healthcare in Mississippi.

Prior to coming to MACM, Burns worked at UMMC first as a staff nurse, then as the nurse educator on the Bone Marrow Transplant Unit. Since 2008, she was the Nursing Workforce Specialist in the Office of Clinical Excellence at UMMC. In this role, Burns coordinated and managed numerous projects and hospital-wide nursing initiatives.

Burns received both a bachelor's and master's degree from the UMMC School of Nursing. She is active in local, state, and national nursing organizations, recently serving as the secretary of the Mississippi Nurses Association Board of Directors.

Q&A with Michelle Burns, MSN, RN

What are your philosophy and thoughts about risk management for physicians and their office staff?

I believe there can be enormous time, energy, and resources spent on risk management, but without good communication and documentation, the effort is wasted or ineffective. In the healthcare business, I believe establishing relationships and mutual trust cannot be underestimated as a key ingredient to reducing risk. This can be accomplished by communicating with each other.

What do you consider to be your greatest responsibility to the insureds of MACM?

I feel my greatest responsibility to MACM insureds is to encourage them to keep a "patient first" attitude and to work with them to determine how they can keep their medical liability risk low while giving their patients the best possible care. I absolutely believe that any support and/or resources they can get from us to make their job easier and to allow them to spend more time with patients is immensely beneficial.

For an insured, what do you consider to be the biggest benefit of MACM?

I believe having trustworthy relationships where our insureds know they can pick up the phone and call MACM staff if they have questions. Since I have been at MACM, I have watched the risk management consultants research questions from insureds and then quickly respond with an answer. It is a huge benefit to our insureds to have a team dedicated to serving them and looking out for their best interests.

ENDURING THE CHALLENGES OF MEDICINE

A great time was had by all – and much learning took place as well – at the Sheraton Hotel on Canal Street in New Orleans for the 2015 MACM CME Program held September 18-19, 2015. MACM insureds, clinic representatives, and defense counsel from across Mississippi journeyed to the heart of the New Orleans Business District to hear nationally-recognized speakers discuss the changes occurring in healthcare and what can be done to ease the transition.

A review of each of the presentations given at the CME program follows.

TACKLING THE CMS QUALITY MEASURES: OUR JOURNEY

Speakers: Bryan N. Batson, MD &
Lisa A. Freeman, RN

Synopsis written by Maryann Wee, RN, BSN

The first speaker in this presentation was Bryan N. Batson, MD, whose specialty is internal medicine/pediatrics. Dr. Batson is the Director of the Hypertension Clinic at Hattiesburg Clinic and serves as the Chief Medical Information Officer for the clinic. In addition to Dr. Batson, Lisa Freeman, RN, who serves as the Clinic Risk Management and Compliance Officer for Hattiesburg Clinic, was a presenter.

Dr. Batson and Ms. Freeman discussed the challenges they encountered while developing and implementing a successful quality improvement program based on CMS quality measures at Hattiesburg Clinic. One of the major challenges faced was handling multiple quality measures and programs that the federal, state, and private insurers mandate. Using the example of breast cancer screening, Dr. Batson explained to the audience how they at Hattiesburg Clinic look at all the different quality measures derived from multiple organizations and develop a single comprehensive measure, which will then meet all the requirements from the multitude of payers.

Functionality of the EMR also played a key role in the development of quality measures. The strategy was to start with only three simple measures (flu vaccine, pneumococcal vaccine, and mammogram screening) and develop a system that would get the providers at Hattiesburg Clinic comfortable with the process and not overwhelm them. The EMR not only gave the providers a pop-up reminder that the measures were needed, but the orders were also integrated with the pop-up reminder, thus eliminating the need for the physician to leave the EMR page to execute an order. Once these pilot measures were successful, the team expanded to include more complex chronic disease management, such as diabetes (measuring the completion rates of foot and eye exams and A1C control).

The next stage was to examine operational steps that have promoted reductions of variances in clinical practices. The clinic used several provider committees to "set the standard" and give a target goal. The success of getting the information to the providers was in having the right EMR. The team worked with the Hattiesburg Clinic vendor to develop a "report card" of the individual provider's progress in meeting the goals and how they compared to their colleagues. This "report card" popped up when the provider logged in, thus providing easy access.

The team at Hattiesburg Clinic found they were making good progress with their screens but then faced a plateau in the progress. It seemed the providers did not have enough time to provide the incentive for the patient to be compliant. In July 2014, CMS introduced a new Chronic Care Management code which provides for reimbursement for non-face-to-face time with Medicare beneficiaries who had two or more significant chronic conditions. The clinic developed care teams of registered nurses who worked under physician-developed protocols for chronic conditions. They enrolled patients in the program, and the nurses contacted the patients by phone on a regular basis to encourage their adherence to their care plan and work out problems. The results were gratifying, and it is felt that the expansion of the care team has been integral to closing the quality gaps.

What's in the future for Hattiesburg Clinic's Quality Improvement team? Continued expansion of the care team and developing Transitions of Care program with the local hospital to cut down re-admissions. Both Ms. Freeman and Dr. Batson admit this was not an easy journey, but the improvement of the quality of care, which can now be measured, was worth it.

HEALTHCARE REGULATORY UPDATES

Speaker: Richard D. Sanders, Esq.

Synopsis written by Michelle Burns, RN, MSN

Richard D. Sanders provided a dynamic presentation that primarily focused on the most current implications for Mississippi physicians regarding the Patient Protection and Affordable Care Act and the Supreme Court decisions resulting from recent legislation. Among the topics discussed was an overview of federal and legislative changes in healthcare that affect physician practice and how the new laws will impact daily delivery of patient care. The prevailing theme of the presentation was "change is constant," and Mississippi is not unique in the challenges that physicians face on a daily basis. Although there may be different dynamics to consider, physicians across the country face a myriad of regulatory requirements that must be dealt with on an individual basis.

Sanders addressed some of the top health reform stories that were being discussed in the legislative and healthcare arenas during the week of the conference. They included the following:

- Defunding of Planned Parenthood – On the day of the presentation, a bill had been presented to the legislature seeking to avert a government shutdown. Sanders discussed various scenarios that failure to fund the program would have on physician practices and the direct collective impact a shutdown would have on other programs, in particular, those practices where there is a large military and federal employee presence.
- Health Insurance Exchange – Sanders explained some of the glitches in the system and the incumbent tax fraud that has ensued. Attendees were given an opportunity to ask questions and express opinions related to the topic.
- Report from the Census Bureau that the uninsured population dropped by 8.8 million in 2014 (Washington Post) – This discussion focused on how federal regulations impact insurance networks and insurance plans, how competition impacts rates and premiums, and how higher deductibles impact physician practice and reimbursement.
- Meaningful Use Program – Stage Three of the Meaningful Use Program is scheduled to begin soon. During the week of the conference, the U.S. House lawmakers introduced a bill that would grant more flexibility for reporting requirements and would possibly delay the deadlines for starting the program.
- All-Products Clause – Physicians were encouraged to review their health plan contracts and become familiar with the "all-products" clause. As it was explained, the incorporation of this clause into the physician health plan contract is non-negotiable and requires physicians to participate in all health plan products, either in the present or future.

There is no doubt the healthcare environment is in the midst of rapid and constant change. At the forefront of physician practice is the objective to provide high quality and safe patient care. Keeping pace with local and federal legislative requirements can be a challenge; however, it is imperative healthcare providers keep abreast of current and proposed regulations and understand how changing regulations will impact their practice and patient care.

THERE IS NO DOUBT THE HEALTHCARE ENVIRONMENT IS IN THE MIDST OF RAPID AND CONSTANT CHANGE.

STRANGE BUT TRUE:
A 17 YEAR MALPRACTICE CLAIM ODYSSEY

Speakers: Stuart Robinson, Jr., Esq &
Keith Westbrook,
Synopsis written by Michelle Burns, RN, MSN

In the spring of 2014, Defense Counsel Stuart Robinson, Jr., ended a lawsuit against a MACM insured physician that lasted 17 years. The appeal system was used, and the case was heard at every level of the judicial system. Robinson and MACM claims representative Keith Westbrook shared the facts of this cautionary tale and focused on lessons learned from their vast experience in defending physicians and as a result of this very atypical case. The real-life scenario that was presented seemed more like a John Grisham novel; however, many in the audience could relate to the complicated nature of the case due to experiences they have had in their own personal practices.

The attendees were intrigued as Robinson and Westbrook recounted the details of the case and interpreted the common themes that can discredit physicians in a court room. By far, the most common and preventable problem defense attorneys face when defending physicians is the lack of thorough and timely documentation. Additionally, Westbrook emphasized that it is imperative for physicians and healthcare providers to stay attune to their gut instincts and to "not ignore red flags."

From a medical liability standpoint, the case that was presented offered many valuable lessons that can help physicians reduce their medical liability risk. No physician dreams to be in a situation where they feel they need to defend their actions or medical treatment. However, should a situation present itself where physicians do need to defend themselves in a medical liability suit, there are several actions and resources that can help strengthen the case and their defense. Throughout the presentation, Robinson and Westbrook advised physicians to incorporate the following recommendations into their daily practice:

- Do not ignore red flags and listen to your gut instinct.
- Be very specific in obtaining patient history and then be sure to document your findings.
- DOCUMENT everything! Ensure your documentation tells a story and paints a true picture of the situation. It is OK to document information obtained from a family member or conversations with other people besides the patient that may be pertinent to the situation. It is best practice to ensure documentation reflects the clinical care that patients receive and that anyone reading the medical record can determine the story that is being told about the care.
- Document phone calls. Ensure your clinic or practice has protocols for managing and documenting after-hours phone calls. Plaintiff attorneys will always live by the adage, "if it is not documented, it was not done!"
- Use the Mississippi Prescription Monitoring Program (PMP) to your advantage as a tool to ensure the patient history matches PMP and prescription history.
- Monitor your personal PMP records. Do you know what the PMP is reporting about your prescribing habits? By periodically monitoring your PMP records, problems may be identified early. It is a good habit to ensure your PMP records are a true reflection of your practice.
- Include the patient PMP record in the permanent record, when indicated or questionable.

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THE DEA AND PHYSICIANS:
A PARTNERSHIP IN THE MAKING

Speaker: Keith Brown

Synopsis written by Judy Cleveland, RN, BSN

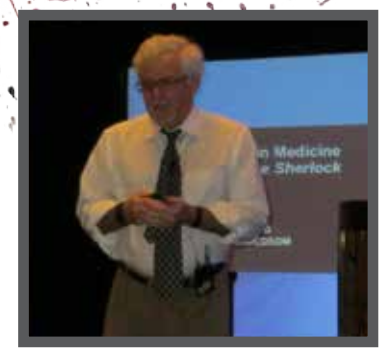
Agent Keith Brown began his presentation by noting that both law enforcement agents and physicians take an oath at the beginning of their careers. Law enforcement officers take the Law Enforcement Oath of Honor and physicians take the Hippocratic Oath. At the core of both is a directive to do what is best for the public — meeting our obligation to our fellow man to do what is right. He pointed out that even though the paths taken to achieve careers in medicine and law enforcement vary greatly, for most people, the end goal is the same — to help others.

The first drug Brown mentioned was heroin. He started with this as heroin is back in the picture with a vengeance. Today's heroin is 25 percent pure or higher, so it no longer has to be injected to induce a high; it can be snorted or smoked easily. So what does heroin have to do with prescription medications? The majority of today's heroin addicts started with the abuse of prescription medications. Brown stated that in all his years of law enforcement, he has yet to come across a heroin addict that did not start with prescription drug abuse. Often it is a case where a physician eased into providing too many pain medications without even realizing what was happening. It happens once, then again, and soon there is a pattern. Once a physician gets a reputation as being an "easy touch" for controlled medications, word spreads quickly, and it becomes more and more difficult to stem the tide.

Agent Brown focused on areas in which physicians are vulnerable and actions they can take to protect themselves while still providing care:

- Keep all prescription pads locked up. This one is common sense, but it does not always happen.
- Check the PMP (Prescription Monitoring Program) frequently. Physicians know that they can check patients on the PMP but they often do not realize they can also check under their provider name to see what prescriptions have been issued under their DEA number. The PMP can significantly decrease doctor shopping, but only if it is used and used frequently.
- The leading diversion issue is patients who resell partial prescriptions.
- You have to have a valid physician-patient relationship to issue a prescription.
- There must be documented, valid medical necessity for issuing a prescription for a controlled drug. This includes more than just pain medications. Drugs such as Xanax and Adderall are problematic too.
- If there is a problem with a patient and you learn that they have altered a prescription, don't just simply discharge them from your care. Notify law enforcement, such as the DEA or the Mississippi Bureau of Narcotics.
- Your DEA number is yours. It is attached to your name and to your reputation, so protect it.

NOTE: Currently the Mississippi PMP is linked with 11 states: Arkansas, Tennessee, Louisiana, Kansas, North Dakota, Arizona, Illinois, Minnesota, Michigan, New Mexico, and Idaho. Recently an agreement was reached with Alabama, and it is hoped Mississippi will be linked with Alabama by the end of 2015.



DIAGNOSTIC ERROR IN MEDICINE:

THINKING LIKE SHERLOCK

Speaker: Dennis J. Boyle, MD

Synopsis written by Kathy Stone, RN, BSN

Dr. Boyle began his presentation by discussing the two basic types of thought processes. System 1 thought is quick, instinctive, and even emotional, while System 2 thought is slower, more deliberative, and logical. A good example of a System 2 thought process in medicine is the use of differential diagnoses.

Inexperienced people use System 2 thinking the majority of the time, while System 1 thinking – the instinctual, automatic type of thinking – is only used approximately 5 percent of the time. As we gain experience, this pattern becomes inverted with experts using the System 1 process approximately 75 percent of the time and System 2 (i.e. differential diagnoses) only 5 percent. (Following known rules accounted for the remaining 20 percent.) This is appropriate in most situations; however, medical errors occur most often when a provider employs the System 1 thinking in a situation which really requires the more sophisticated and thoughtful approach of System 2. We don't always put information together well so that we arrive at the correct conclusion.

Studies have shown that even in the best medical centers, diagnostic errors occur at about a 2 percent rate. But, since the errors were self-reported, it is suspected that the real error rate was more than 7 percent. In 2002, a now familiar study was published in JAMA that stated that we in the healthcare field lose an average of 80,000 patients each year due to medical errors of various types. This is the equivalent of a jumbo jet crashing daily for a year. Another study reviewed 100 cases with medical errors and discovered that there was actually an average of 6 different errors per case. The Swiss Cheese Model explains this phenomenon in which an error occurs when several lapses in multiple system layers of defense line up so that the multiple layers in place to prevent an error are rendered useless.

Medical errors are related to a variety of issues including patient non-compliance, systems problems which make it easier for a provider to miss important information, and even a lack of information regarding a disease process which does not become evident until further study and experimentation in the field occurs. Healthcare providers have minimal ability to prevent errors resulting from these issues. What healthcare providers can control is their own cognitive ability and process. But this takes awareness and understanding of how to prevent cognitive errors. There are as many as 100 different cognitive errors. These occur primarily due to System 1 biases. Some of the more common biases were described such as affection, availability, framing, satisficing, alliterative, and anchor biases.

MEDICAL ERRORS OCCUR MOST OFTEN WHEN A PROVIDER EMPLOYS THE SYSTEM 1 THINKING IN A SITUATION WHICH REALLY REQUIRES THE MORE SOPHISTICATED AND THOUGHTFUL APPROACH OF SYSTEM 2.

Dr. Boyle presented a Top 10 list of methods providers could employ to combat a tendency towards cognitive biases.

TOP 10 METHODS TO COMBAT COGNITIVE BIASES.

10 **Reflective listening and building a story**. Studies show that obtaining a good patient history alone – without any additional workup – leads to a correct diagnosis over 70 percent of the time. So, let the patient talk. And, ask open-ended questions to encourage it.

9 **Remember most physical exam findings are sensitive but not specific.** The exam findings may clue you to a problem but not lead you to the specific problem.

8 **No test is objective.** It is imperative that providers talk to radiologists and pathologists. This used to be done routinely; but, now providers usually look at the films themselves or simply read the report without discussion.

7 **Build your knowledge base – and try to figure it out.** Google can be a provider's friend. If you don't understand something or can't find a connection between multiple symptoms/findings, consider using the internet to research similar occurrences.

6 **Use your Bayes – think probability.** Don't make an assumption about the frequency, high or low, of a diagnosis based on your best guess. Our biases tend to over- or under-estimate diagnosis prevalence.

5 **Be aware of bias.**

4 **IT is coming (think Amazon books); but, we are not going away!** Information technology, as pervasive and helpful as it is, can never replace the human factor that knows when to override a formulaic or programmed approach.

3 **Take a diagnostic time out.** Just as surgeons have learned the value of this, so should diagnosticians know when they need to take a moment and think through a situation.

2 **Always ask, "What else could this be?"** This may be the simplest, and yet most valuable, tactic a provider can employ to combat any unrecognized biases.

1 **Think like Sherlock.** Sherlock Holmes utilized both System 1 and System 2 thinking to arrive at a correct conclusion. Don't rely on System 1 to the exclusion of System 2. Both are valuable in reaching a proper diagnosis.

TELEMEDICINE:
USING TECHNOLOGY TO DELIVER HEALTHCARE

Speaker: Curtis Lowery, MD

Synopsis written by Anne Everett, RN, MSN

Dr. Curtis Lowery highlighted how technology-based healthcare can be used to make healthcare better and more efficient. He described how this technology has improved healthcare delivery in Arkansas, where he serves as the Professor and Chair of the Department of OB-GYN at the University of Arkansas for Medical Sciences (UAMS) in Little Rock. Through his expertise, Dr. Lowery founded the UAMS Center for Distance Health, a technology-based partnership of the College of Medicine and Regional Programs.

Dr. Lowery pointed out the delivery of rural healthcare is different than that of urban healthcare. In rural states such as Arkansas, many residents must drive for hours to meet with a physician, and it is not efficient to send these physicians out to the outlying rural areas. In a state where, 73 of 75 counties are designated as medically underserved, access is the most overwhelming reason for Arkansas' poor health standing.

Prior to the 2003 founding of the Center for Distance Health (CDH) and ANGELS (Antenatal & Neonatal Guidelines, Education, Learning System), the state's first organized clinical telemedicine program, there were only three maternal/fetal specialists in a state that saw some 40,000 births per year. Through the establishment of the ANGELS telemedicine model, Arkansas' obstetrical and neonatal providers and their high-risk patients now have support 24 hours a day and seven days a week via a telephone call center, education, and direct care that is available face-to-face, as well as via interactive videos. These telemedicine networks have helped close the gap in regions without enough physicians to provide care for women with high-risk pregnancies.

The CDH provides care across the distance, but works in the same manner as when a physician's practice, prior to telemedicine, would use referrals. Now, instead of referring a patient to "Little Rock," physicians refer the patient to the Telemedicine Network where specialists may render an opinion and offer treatment and support. Dr. Lowery pointed out that the telemedicine network system does not seek to take patients away from community providers but to help these providers by using technology to support them. Connected health aims to maximize healthcare resources and provide increased, flexible opportunities for consumers to engage with clinicians and better self-manage their care.

According to Dr. Lowery, there should be no disruption of the doctor-patient relationship with the use of telemedicine. With some telemedicine practices, the customer can call and talk to a company-assigned physician. That physician may render an opinion and call in a prescription without further contact or follow-up with the patient. These types of encounters do not support the doctor-patient relationship model.

In conclusion, Dr. Lowery stated that if healthcare providers are going to survive in a changing world, we are going to have to adapt or be left behind. Through this system approach of providing healthcare to the needed level of the patient, telemedicine improves patient care, cuts down on production costs, and improves safety for healthcare providers.

IF HEALTHCARE PROVIDERS ARE GOING TO SURVIVE IN A CHANGING WORLD, WE ARE GOING TO HAVE TO ADAPT OR BE LEFT BEHIND.

Houston's Handoffs

Continued from page 3

On the physician side, at discharge hospitalists refer patients back to the primary physician. The proper handoff and follow up arrangements are very necessary. Mechanisms need to be in place to ensure that the physician gets a timely, accurate, and detailed discharge summary that includes the diagnosis, a summary of the hospitalization, consultants' reports, and surgeries and procedures performed. Lab and radiology results that are available and also those that are pending and need prompt attention should be forwarded to the attending. An updated medication list is essential. A follow up appointment with the patient's primary physician and any appointments for lab, radiology, or procedures should be made before the patient leaves the hospital. In the handoff, the primary physician must be made aware of any and all follow up visits and testing that has been scheduled. If for some reason it is not scheduled, the physician needs to be made aware so that his office can arrange.

Each institution has its own way of getting information back to the primary or referring physician. It may be sent by facsimile, electronically as an email, or directly into an EMR. And the speed of this transfer of information is variable. Ideally it should get there before the patient presents for his appointment, but it does not always. The best handoff in all situations is that personal phone call from the hospitalist to the primary physician; at this time, the hospital course is reviewed and follow-up plans are outlined.

With the appropriate use of handoffs and effective communication between physicians and staff, both inside the hospital and out, patients can be assured they are receiving the best care possible.

Strange But True

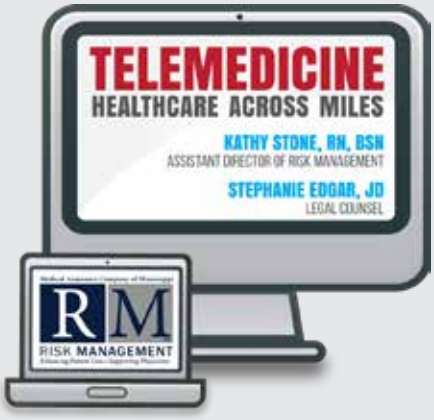
Continued from page 14

- Ensure informed consents are specific and documented! Include verbal instructions that were given and be clear the patient verbalized understanding of all the information. Just saying, "informed consent obtained" or using blanket consent forms increases the potential for jurors and plaintiff attorneys to have questions and doubt.

- Be involved in the election process and know the stance of elected officials.

It is a fact – you can't control what other people do, but in the litigious society we live in, physicians can be proactive and take precautionary measures to protect themselves and their practice. And, if in doubt, the MACM staff is available to help identify and mitigate potential risks.

First MACM Webinar Declared a Success!



Through feedback and participation, the first MACM webinar – **Telemedicine: Healthcare Across the Miles** – was declared a huge success. **Telemedicine: Healthcare Across the Miles** is now available to be viewed "on demand".

If you are interested in access to the webinar, please email Yevgenia Wilkerson in the MACM Risk Management Department at yevgenia.wilkerson@macm.net and provide the following:

- **Name and Title**
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Once we receive this information, we will email you a link, user name, and password to access the webinar.

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