Don't Just Assume...Or You May End Up As a Defendant

By Kathleen W. Smith, JD

Bear with me, but I *presume* you are familiar with the colorful colloquial saying about what happens to us when we *assume*. (If not, just Google it. I will spare you the quote itself, in an effort to maintain some level of decorum.) Despite this "advice," we make assumptions daily. We assume that events will occur as they are supposed to occur. We assume that people will do what they are supposed to do. For the most part, fortunately, our assumptions materialize and all is well. The problems arise, however, when our assumptions do not develop as we predicted. Medicine is no exception to this assumption trap, and when a physician makes an assumption about a patient's care, that assumption can end up making a plaintiff out of the patient and a defendant out of you.

In this example case, Ms. White[i] was a young, morbidly obese, one pack-per-day smoker patient who underwent an abdominal gynecologic surgery on January 15, 2017. She was given a prophylactic antibiotic pre-operatively. On post-operative day one, January 16, 2017, Ms. White's abdominal incision was confirmed to be clean and dry with the steri-strips intact, she was stable and recovering well from the surgery, and she was discharged home.

Five days later, on January 21, 2017, Ms. White returned to the ER complaining of fever and drainage from her abdominal wound. Dr. Smith, a gynecologist in the same group as the original surgeon, re-admitted Ms. White to the hospital, where he ordered a culture of the abdominal wound, prescribed IV Ampillicin and Flagyl, and performed a dressing change with clean-out and repacking of the wound. Ms. White remained in the hospital for the next two days, receiving IV antibiotic therapy. During this time, her condition improved overall. By January 23, 2017, Dr. Smith determined that Ms. White was ready for discharge, and he placed a telephone order for her discharge. Another partner in the group, Dr. Jones, was physically present at the hospital when Dr. Smith gave the telephone discharge order. Accordingly, Dr. Jones went ahead and carried out the patient's discharge for Dr. Smith.

The following day, January 24, 2017, the hospital's laboratory released the final report for Ms. White's January 21st wound culture. The report advised as to the culture and sensitivity of the bacteria infecting her abdominal wound, which was, unfortunately, not sensitive to the antibiotics that she was prescribed. The final wound culture report was not disseminated beyond the hospital walls. Neither Dr. Smith nor Dr. Jones were made aware of its findings.

Two days later, on January 26, 2017, the patient returned again to the ER with continued and progressing complaints of fever and drainage from her abdominal wound. The infection was found to be quite advanced. Although Ms. White required extensive surgical and wound care over a prolonged period of time, she was ultimately able to recover from the infection. Ms. White subsequently filed a lawsuit over her care, and named Dr. Smith, Dr. Jones, their group, and the hospital as defendants.

Not surprisingly, the wound culture report became a key medical record in the lawsuit. Ironically, although the wound culture report played such a significant role in the lawsuit, it appears to have been completely overlooked by the physicians when they were actually treating the patient. Likely, the doctors assumed that the results of the culture would be reported to them, one way or another, regardless of whether the patient was still an in-patient or whether she had already been discharged from the hospital. Nevertheless, the physicians' assumptions about the outstanding wound culture set in motion serious complications for this patient, which served as the basis for her lawsuit against them. Although we could not save Dr. Smith and Dr. Jones from the consequences of their assumptions, you can learn from their lesson and avoid making it in the future.

1. Do follow up on outstanding test results. If the testing was important enough to order, then it is important enough to follow up on. Ultimately, the ordering physician will be charged with bearing some degree of responsibility for knowing the results of the testing he ordered, regardless of what others did or did not do concerning its final report.

2. If there is a partner or call group assisting with the patient's care, do make the covering physician aware that there are test results still outstanding. It may not be immediately apparent to a covering physician that the test has been performed, but the results have not yet been returned. This allows the covering physician to be aware that there is a piece of information still unknown about the patient, and it enables the covering physician to follow up on the status of the outstanding results, too.

3. When preparing a patient for discharge, consider whether there are still any test results outstanding. If so, consider whether the discharge is not yet timely. If it is ultimately determined that discharge is appropriate despite an outstanding test result, make sure there is a plan in place for discovering the results of the outstanding testing. Further, when appropriate, enlist the patient in the follow-up plan and make sure that the patient understands any role she may have in learning the results.

4. When discharging a patient from the hospital with tests outstanding, consider whether to

leverage your existing in-office tracking system. While it may generally be true that the hospital's laboratory would or should inform you of the results of inpatient testing, do not rely only on this. Such an assumption may be detrimental to your patient's health, and may result in you being named as a defendant in a lawsuit that you could have otherwise avoided.

[i] All names have been changed

Potential Risks and Pitfalls of EHR Systems - Part II

By Jeffrey A. Woods, JD

In Part I last month, we discussed the potential risks and pitfall of EHR systems relative to digital assists and inconsistent processes. In this month's article, we will examine additional concerns unique to EHR systems that could create potential risks for the provider including the audit trail and alerts/pop-up warnings.

Every EHR system has an audit trail. The timeline is no longer a guessing game. Gone are the days of using handwriting experts to try to determine when and by whom an entry was made in a patient's chart. Forensic IT experts can now review the "metadata" contained within the EHR, which is basically the DNA of the EHR, to determine everything that occurred in that chart, including:

- Date and time stamp of records
- Who accessed the information
- On what occasion(s)
- For how long
- What records were accessed
- What records were available to the provider, but were NOT accessed

In the context of a claim or lawsuit, the audit trail does not play favorites. Unfortunately, for many providers, the audit trail is unforgiving. The record is what the record is, and the audit trail will either support the provider's position or sink it. If, for example, a radiology report or lab result was available to the provider prior to the patient's discharge, but the report/results were never reviewed, the audit trail will establish this fact. Similarly, if the standard of care (as established by expert testimony) requires a radiologist to spend a certain amount of time reviewing studies and the radiologist actually spent significantly less time performing that review than was typically required by the standard of care, this will be borne out by the audit trail.

Because every keystroke in an EHR is recorded with a time and date stamp, alterations should not be made to the EHR after a claim or lawsuit is asserted without first talking with an SVMIC Claims Attorney or defense counsel. Any amendments, supplementation, corrections, and/or addendums made after an adverse event will likely be viewed suspiciously and as self-serving. It should be remembered that the plaintiff's Forensic IT expert(s), who will be reviewing the metadata (audit trail), will do so at a much later time, typically, during the discovery process prior to trial. If a correction to the EHR should be

made for continuity of care purposes and there is no claim or lawsuit pending or threatened, these corrections should be made in the same manner as with paper charts, i.e. clearly identifying that it is a correction/supplementation, the reason necessitating the change, the date, and who made the change.

Additionally, EHR documentation should be performed contemporaneous with the event or as close thereto as possible. The audit trail will reveal the time differential between the event and the recording of the event. If significant time is allowed to elapse, the accuracy of the provider's documentation may be called into question.

Audit trails can also be used by hospital administration and law enforcement authorities to determine if a healthcare worker has improperly accessed a patient's records. Laws are firmly in place that protect patient confidentiality and guide healthcare administrators and staff as to the ethics and legality surrounding proper access and disclosure of medical records. Under HIPAA, generally, a covered entity may use and disclose protected health information ("PHI") for its own treatment, payment, and health care operations activities. If a healthcare worker has accessed a patient's records for any purpose other than one of these three authorized uses, and it is discovered through a review of the audit trail (whether it is discovered by routine audit or patient complaint), the potential consequences for the provider can include one or more of the following: employment termination, an ethics investigation, a civil lawsuit, and criminal prosecution.

If a provider shares his or her log-in information with a staff member or permits someone else to sign an EHR electronically using e-signature, it will appear from the audit trail that it was the provider who accessed the EHR or signed the record. This could be problematic in a claim where the record is in question. It could also be a violation of third-party payer contracts.

Alerts or pop-up warnings are also unique to EHRs and are utilized as a means of calling attention to something in the patient's record. These warnings can relate to such things as: allergies, medication dosages and interactions, follow-up needed, etc. Their purpose is to assist the provider and staff to deliver better, safer care by acting as a safety net to remind the provider/staff of important information regarding the patient. However, the number and frequency of these alerts/warnings can often become unduly burdensome. The result can be that the provider/staff develops "alert fatigue/numbness" and ignores the alert warning or deactivates the alerts altogether. The better practice is to manage the alert settings. In the event an alert is routinely disregarded, the practice should evaluate the purpose of the alert and, if appropriate, work with the EHR vendor to modify the alert as needed to make it more useful.

When a provider believes there is not a good medical justification for adhering to the recommendations of the alert, the provider's reasoning should be documented in the patient's chart. Alerts should be used to flag a patient's medical record to draw attention to needed follow-up in the event a different provider sees the patient at the time of the next visit.

An additional concern unique to electronic records is that printouts of the EHR can sometimes differ significantly from the image that is on the monitor screen being viewed by the provider. This can create problems and cause a record to be suspect when a patient or his/her attorney requests a hard copy printout of the medical record. Practitioners and staff should be familiar with what information is and is not printable from the EHR. If a patient, representative or attorney requests copies of the EHR, the hard copy should be reviewed to insure it is complete and any discrepancies noted prior to forwarding the information to the patient/representative/attorney. You should contact an SVMIC Claims Attorney prior to responding to any medical records request if you suspect that a claim or lawsuit may be forthcoming.

Finally, with respect to EHR systems, it is important to keep the focus on the patient and not on the screen. Many patients do not understand why their provider spends more time focused on the computer screen rather than on them and their condition. It is often beneficial to involve the patient in the documentation process by reviewing the prior notes in the EHR, allowing the patient to view the screen as new information learned from the visit is added and explaining how the system works. When the purpose and capabilities of an EHR system are explained to patients, it helps the patient who is attached to paper files become less apprehensive about the EHR and lessens the possibility that the patient will feel ignored.

While electronic communication has revolutionized the care provided within healthcare, it is important to remember the risks involved and how to mitigate them. Moreover, the primary focus should always be on the patient. Maintaining a good physician-patient relationship often will be the best defense to prevent a malpractice claim or lawsuit.

Spring Cleaning: Seven Strategies for Your Practice

By Elizabeth Woodcock, MBA, FACMPE, CPC

The spring offers a chance to shake off the winter blues – and get started on an improvement initiative for your practice. Make a commitment to focus on one area in your practice. Select a task, create a workgroup, pledge to meet once or twice a month, maintain a written agenda, and document an action plan. Choose a quantifiable measure of success – and monitor it. Don't let 2019 slip by without taking a deep dive into an area of opportunity in your practice. The choice is yours, but here's a list of topics to consider for your spring project.

- **Take a Stand**. It comes as no surprise that physicians are increasingly subjected to arduous administrative burden. The American Medical Association, for example, reports that every week a medical practice completes more than 29 prior authorization requirements per physician, which consumes an average of 14.6 hours to process.[1] The AMA is one of many professional associations focused on reducing the burden related to prior authorizations. This is an opportune time to engage in advocacy. Request a written copy of your participation agreements with insurance payers, and understand the contract requirements – instead of just being told "this is what you have to do." Report problems with payers' provider enrollment processes, adjudication or reimbursement to your state insurance commissioner, medical society and local legislator. Engage in advocacy at the federal level with your professional society or association. It's time to assert your voice.

- **Recognize the Power of the Template**. The schedule is the central nervous system of the practice, yet it's rarely given the attention it deserves. Focus on the framework for the schedule – does your supply (of time slots) meet your demand (for appointments)? Dive deep into the template: When your scheduler searches for the "next available" slot, what does that query deliver? Many systems populate the third-next available appointment, or simply skip to the next day; you could be systematically "losing" slots without realizing it. Evaluate your start times for both the morning and afternoon clinics; does the clinic really commence at 8 a.m. or is that an appointment with the receptionist at your front ? Consider your appointment types; do you really need that many? As patients equate access with quality, this evaluation becomes more important than ever. Remember: You can never outperform your schedule.

- **Acknowledge Consumerism**. While we give attention to managing generations at

work, we may be overlooking the fundamental change in our customer base. Our customers have high expectations when it comes to quality and service delivery. Marry this with higher financial responsibility, and recognize that a sea change is underway. If we want to be successful at collecting revenue, we must ensure our operations reflect this new reality. Self-scheduling is no longer optional for your practice; it's simply a matter of when and how, since your very survival is dependent on executing strategies that customers don't just want, but expect. We can resist these new customer demands, but we risk our competitors overtaking us. Even if the practice across town remains static, competition is emerging from faraway places. Every one of your patients carries a computer in their pocket – change may come from yet-identified sources. It's vital to recognize the emergence of customer awareness before it's too late.

- **Empower the Patient**. Patient engagement has peppered the soundwaves for several years, but the end game is patient empowerment. This approach has endless possibilities; not only is a more empowered patient a more compliant one, but there are significant benefits to your practice as well. Consider how other industries have empowered customers, such as ATMs at banks, kiosks at airports, and salad bars at restaurants. These solutions provide value to their customer and the business. Patient empowerment offers the same possibilities for your practice. Administrative tasks like completing a medical history that effortlessly populates into the patient's record, and clinical tasks like transmitting biometric data (any type of vitals), translate into advantages for you and your practices. While payment for these activities has been elusive in the past, recent remuneration determinations like the new remote physiologic monitoring CPT codes 99453, 99454 and 99457 are propelling new opportunities. Opportunities may breed additional challenges, however; remember to bolster cybersecurity to manage and protect patients' records.

- **Measure Success**. Most practices have some form of a patient satisfaction survey, however, taking action based on the survey is another story. Keep it simple by focusing on the #1 metric in other industries, Net Promoter Score (NPS) which uses a single question to measure customer loyalty: "How likely are you to recommend our practice to your friends, family and colleagues?"

- **Optimize Technology**. Most practices have implemented electronic health record systems, but workflow integration is only now taking flight. Focus efforts on optimizing technology, such as integrating patients' history and vitals directly into the record, installing biometric switches for your EHR system, and executing smart-phrases, hot keys, and note templates. Create structured technological strategies by engaging with your vendors, posting queries on users' forums, and questioning consultants. Post a position for a graduate student in IT to intern with your practice to identify and implement opportunities. Inconsistent, poorly integrated technology can slow you down. It is an opportune time to optimize your infrastructure, with a focus on productivity, proficiency and efficiency.

- **Address Revenue Vulnerability**. The reality is that patients have significant financial responsibility which presents significant challenges for them. Indeed, patient payments now account for 35% of provider revenue, the third largest source of provider income behind only Medicare and Medicaid, according to a recent "Forbes" article. Without implementing strategies to address this growing trend, your practice will experience bad debt that has the potential to drown your practice. It's vital to establish clear policies, requiring either full or partial payment in advance of the provision of care. Copayment collection is a necessity; indeed, it's a contractual obligation (via the insurance payer) for you to collect it. Requesting payment on the balance is also business critical; pitch these as a convenience for the patient. Patients certainly don't want to be bothered with a pesky paper invoice weeks from now, so taking care of it is a win/win. Indeed, explain that protocols related to price transparency reduce the stress associated with concerns about what they owe and how they will pay. Financial surprises for patients are not only frustrating, they rarely result in full payment for the business. Instill processes to capture pre-service deposits (or, ideally, full estimated patient responsibility) on non-emergent services, and focus on a methodical approach to post-service collections. Incorporate online payment, and distribute statements to patients twice monthly to align collections with patients' paycheck cycles.

Spring cleaning isn't simply about sorting or getting rid of clutter; it's an opportunity to redefine your processes. While you may choose one area of focus for the spring, the impact will be a lasting one. Your efforts can boost the energy and enthusiasm your staff needs to tackle the many challenges faced by your practice.

(1) - https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf

Transparency Revealed: How to Make Payments More Transparent to Patients

By Elizabeth Woodcock, MBA, FACMPE, CPC

Medical practices and price transparency haven't exactly gone hand in hand in the past. With complex reimbursement systems and the real need to focus on other tasks, practices have not always been up front with patients when it comes to revealing the payment due until long after the service is rendered.

Today's patients, however, are clamoring for more information, more education and more transparency. Granted, this can require a shift in procedures and a fresh approach to doing business, yet there are many opportunities to enhance transparency before the patient ever sets foot inside your practice, not to mention a variety of benefits for all parties. From pre-visit financial clearance to appointment calls, from scheduling reminders to initial in-person interactions, transparency around payments can set the right tone well ahead of time for your patients. Your practice also benefits, as a more informed patient offers a higher probability of payment.

Information on pricing is now available to patients online (see, for example, https://www.healthcarebluebook.com/), but it is often confusing and can be inaccurate. Take matters into your own hands by integrating these strategies in your practice to enhance transparency when it comes to pricing:

- **Make an immediate effort**. After you receive and welcome the patient, you can follow through with "How would you like to take care of your payment today?" (Make sure it's "how would you like to…" instead of "would you like to…?"). Ensure that you are ready to accept payment in multiple forms and aim to get more than just the co-pay. Always attempt to settle any outstanding balances. You can even take payments over the phone when scheduling or confirming appointments. For scheduled procedures, surgeries and tests, the appointment process should incorporate a pre-service deposit; this reminds patients of their financial responsibility before the appointment and ensures regular payments for a practice.

- **Be thoughtful in the request.** Learning to make effective payment requests can be a great training opportunity for staff, especially those not well versed in this procedure. Encourage staff to use the patient's name, make eye contact, and provide payment information discreetly if the meeting is in person. Share the benefit summary and any other pertinent information with a smile. Staff should also be trained to calmly handle refusal-to-pay situations with a referral or follow-up.
- **Create efficiencies.** The payment process should be as seamless as possible. If you currently have to leave a station to process a credit card or collect change, determine how you can update this process. The longer that patients wait, the more they will get frustrated or second-guess their decision to make an upfront payment, so the faster, the better, in most cases.
- **Be upfront and honest.** Ultimately, patients want the truth, and they want to understand their financial situation. They will appreciate details being provided ahead of time, so ensure that you have this information readily available for them. Likewise, make sure that all patient-facing staff are knowledgeable when it comes to insurance, which is often changing and evolving.
- **Take advantage of technology.** Many patients appreciate the convenience of making a payment via their phone or online banking. Use technology to make available and accept more online payments. Avoid charging extra fees for such payments.
- **Say "thank you.**" This is such a simple action and such an important one. Patients want to be appreciated and valued. Delivering a sincere "thank you" at the end of the transaction sets the stage for positive future interactions.

When a patient receives a surprising bill a month or six weeks following an appointment, it can create panic, frustration, and/or confusion, particularly if the individual is not presently prepared to pay the bill in full. This can lead to non-payment and no-shows in the future, creating a vicious cycle that benefits no one.

On the other hand, greater transparency in pricing can build both trust and loyalty, while also bolstering communication, and ensuring more positive relationships and payments for years to come. When you focus on being more transparent in pricing and payment requests, your patients may be thanking you.

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