MIEC

The Exchange

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INSIDE

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Ten Risk-Reduction Resolutions for 2016

Happy spring to MIEC policyholders! Welcome to another new year and new promises for change! We originally published this article in 2010, suggesting to you ten risk-reduction resolutions, ways for you — our insureds — to actively mitigate your liability exposure. It was sound advice then and remains prudent advice as we enter a new year. A few new resolutions have been added for you to make this a year of improved patient engagement and effective communication as the underpinnings for safe and quality care.

1 *Resolution 1: I will re-evaluate primary areas of clinical risk in my practice, using data to initiate change.*

Every specialty carries with it clinical risks that can result in significant or severe patient injury. Identify the highest risks and develop policies and procedures to help you mitigate or eliminate the potential for patient harm and decrease your liability exposure. Resources that you can consult include your professional academies or colleges (e.g., discussions that identify areas of risk and/or changes in the standard of care), state and county medical societies, journal articles, data from the PIAA and from CRICO Strategies (available on MIEC's website), federal agencies [e.g., the Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov], and MIEC. As your professional liability carrier, we continually evaluate claims for frequency (how many claims), severity (how expensive the claims are), recurrent allegations, and associated issues that affected the outcome of the claims.

Realistically, it may be impossible to manage all of your areas of risk equally; however, heightening awareness of significant clinical risks and prioritizing efforts to avoid them could result in fewer patient injuries and an improved claims history. The American Society of Anesthesiologists did just that in 1986 when the House of Delegates approved standards requiring qualified anesthesia personnel to be present throughout a procedure when general anesthetics, regional anes-

thetics, and monitored anesthesia care are used, and requiring continuous monitoring of a patient's oxygenation (e.g., pulse oximetry), ventilation, circulation, and temperature during a procedure. Current examples of evolving standards include the use of propofol by gastroenterologists to sedate patients undergoing endoscopic procedures or variations in the use of anticoagulation therapy as determined by surgical specialists.

*See **Table 1** on pg. 9 for a list of MIEC's allegations by specialty that resulted in severe injury and high indemnity payments to patients or their families.*

2 Resolution 2: *I will develop systems to track and manage diagnostic tests, patient referrals, and failed appointments.*

In October 2006, Dr. Tejal Gandhi and his colleagues published a closed claims study in the *Annals of Medicine* in which they concluded that diagnostic errors that harm patients are typically the result of multiple communication and system breakdowns. The researchers studied 307 closed malpractice claims, in which patients alleged a missed or delayed diagnosis, and found that 181 claims (59%) involved diagnostic errors that harmed patients. Some of the most common breakdowns in the diagnostic process were failure to order an appropriate diagnostic test; failure to create a proper follow-up plan; failure to obtain an adequate history or perform an adequate physical examination; and incorrect interpretation of diagnostic tests. A second study, published in the November 9, 2009, edition of the *Archives of Internal Medicine*, found that 44% of diagnostic errors in medicine occurred in the testing phase — namely, failure to order, report, and follow up on laboratory tests.

It is vital for you to have systems in place that will help you track and manage diagnostic test information and follow patient referrals. This year, resolve to:

A. Monitor ordered tests and consultation reports: Ask staff members to help you track ordered tests and consultation reports and determine why expected reports were not received. If results are not returned, staff should call the patients to determine whether or not they completed the tests or visited the specialists as recommended. When patients confirm that they complied, the staff will protect patients and you by following up with diagnostic labs and specialists to obtain results and interpretations.

B. In paper charts, initial reports as evidence of review: To safeguard against overlooked diagnostic reports or consultants' letters, prohibit your staff from filing these items in patient charts until you have initialed them as evidence of your review. In electronic health records (EHR), ensure that you "sign off" on diagnostic or consultation reports before they are scanned into the system. Reports received electronically from labs or consultants should be "tasked" to you for review and electronic signature.

C. Document patient notification in the charts: Often physicians note directly on diagnostic reports that staff should notify patients of the results or call to schedule a follow-up visit. We recommend that staff note in the charts their efforts to contact patients to report negative or normal results, plus initial and date the entries. Staff should document "per Dr. XX" when they give medical advice in addition to reporting

test results. We recommend that you personally contact patients about positive test results or ask patients to return to your office in follow-up to discuss the results or the consultant's conclusions.

3 *Resolution 3:* *I will develop a medication management system.*

According to the PIAA, mismanagement of medications is one of the top five allegations against physicians in all specialties. Failure to properly monitor anticoagulation therapy is an area of increased risk, as is mismanagement of pain medications. MIEC's claims history certainly proves this to be true. Careless charting, illegible prescriptions, and incomplete documentation of prescription details and refills (e.g., reason for the medication, its efficacy, monitoring of therapeutic levels, and indications for changes in dosage) are among the reasons for an increase in these expensive claims.

This year, consider the use of a medication control record to track medications more easily, and make certain that the record is kept current. In EHRs: ensure that the system enables you to e-prescribe; allows you to maintain a current list of medications and their refills, distinguishing between those you prescribe and those prescribed by others; warns you of contraindicated medications or known drug allergies, and more. Don't turn off alerts! They are incorporated in the EHR to at least draw your attention to the medication you prescribed and contraindications based upon patient history and other prescribed medications.

When monitoring anticoagulation therapy: In July 2015, MIEC Claims and Loss Prevention staff, together with Harvard's CRICO Strategies and cardiologist Jone Flanders, MD, presented the webinar *Getting to the Heart of Cardiology Claims: How to Care for Your Patients and Mitigate Risk*, a program that outlined, in part, steps that physicians should consider when treating patients with anticoagulants. Visit www.miec.com. In the Press Room, click on Educational Webinars > On Demand Webinars for access to the program. CRICO Strategies analysts recommended:

Develop structure around anticoagulation management and consider the use of anticoagulation clinics.

- Investigate Anticoagulation Forum, a multidisciplinary organization of healthcare professionals whose mission is to improve the quality of care for patients taking antithrombotic medications.
- Implement practice protocols for office-based management including clinical oversight by RN, PA, or NP.
- Investigate and drive EMR alerts for providers in electronic medication reconciliation and order entry systems to remind ordering clinicians to fully assess the risk of anticoagulation discontinuation both before and after procedures.
- Ensure that patients are both educated and involved in their medication management.
- Improve pre-procedural assessment by investigating best practices that have proven successful (see, e.g., Society for Cardiovascular Angiography and Interventions; Blue Cross Blue Shield of Michigan Cardiovascular consortium model; Michigan Anticoagulation Quality Improvement Initiative's

"anticoagulation toolkit" at http://anticoagulationtoolkit.org).

Improve communication and management of the ongoing care process, including reviewing your processes for:

- Routine testing/result management
- Monitoring/adapting
- Case review regarding communication breakdowns
- Apology and disclosure

Cardiology Consultant Jone Flanders, MD, reminded policyholders to be familiar with ACC/AHA *Guidelines for Management of Atrial Fibrillation and Anticoagulation* and to assess patients using the CHA2DS2-VASc and HAS-BLED schemas.

When managing pain: Register and frequently reference your state's prescription drug monitoring program for information about your patients' medication history; have patients sign a medication agreement to clearly define your pain medication management relationship; develop progress notes that allow you to document elements of your treatment according to your Medical Board's guidelines and/or those outlined by the Federation of State Medical Boards; and more.

Medical society safe prescribing coalitions: This year, look to your state and local medical society for resources for safe prescribing. For example:

- Alameda–Contra Costa Medical Association (ACCMA)—East Bay Safe Prescribing Coalition
- San Diego and Imperial County Prescription Drug Abuse Medical Task Force endorsed by the San Diego County Medical Society and Imperial County Medical Society
- North Valley Medical Association, partnering with Partnership Health Plan and others to promote safe medication practices (http://norxabuse.org)

4 *Resolution 4: I will work with patients and staff to improve patient satisfaction and increase patient engagement.*

It's been over three years now since CMS began connecting patient satisfaction to Medicare reimbursement using tools such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and the clinic version of the same questionnaire to measure satisfaction. Conclusion: There are mixed reviews on survey results and their significance as high scores for *perceptions of care* may have little connection to *outcomes and quality of care* and may even result in increased healthcare costs. Some sources maintain, however, that improved patient satisfaction serves to enhance community reputation, increase patient loyalty, reduce professional liability claims, improve efficiency, and create greater employee and physician satisfaction (first reported in the 2008 Press Ganey Client Survey).

MIEC continues to believe that improved patient satisfaction is a deterrent to litigation. We recommend that you pursue resources that can assist in your efforts to obtain meaningful feedback from patients, information that reflects on their experience with you as their physician and with your staff. Encourage patients to complete the surveys they receive from their insurance carriers and solicit the results from those carriers. Develop your own survey—it does not need to be complicated. If you are part of a large group and use centralized billing, consider a resource such as SurveyVitals (www.surveyvitals.com) to track patient satisfaction in real

time. Resolve to obtain patient feedback and effect change in your practice based upon repetitive complaints.

MIEC also acknowledges that patient satisfaction isn't the only avenue to an improved physician-patient relationship and quality care. "One step towards achieving quality care is getting patients more engaged in their health by working with their providers to better understand the treatment that they are receiving."[1] Experts, such as Judith H. Hibbard, DrPH, Professor of Health Policy at the University of Oregon, maintain that quality of care and outcomes can only improve with heightened patient engagement. The process includes assessing your patients' ability to actively engage, that is to "have the skills, ability, and willingness to manage their own health and health care."[2] Use tools such as a Patient Activation Measure (PAM)—"a validated survey that scores the degree to which someone sees himself or herself as a manager of his/her health and care."[3]

This year work to help your patients increase their level of engagement in their own health care. Assess their capability to actively participate. Help patients arm themselves and their families with questions such as those outlined in The Joint Commission's SpeakUp™ program — free for physicians and patients. Use every opportunity, with your staff's assistance, to educate patients and encourage them to actively engage in shared decision-making (see **Resolution 6**).

1 Simmons, Janice, for HealthLeaders Media, "Patient Engagement Occurs One Step at a Time," http://healthleadersmedia.com, March 11, 2010.

2 James, Julia, Health Policy Brief: "Patient Engagement. People actively involved in their health and health care tend to have better outcomes—and, some evidence suggests, lower costs," *Health Affairs*, February 14, 2013

3 Ibid.

5 *Resolution 5:* *I will participate in disclosure training with MIEC or at my local healthcare facility where I have privileges.*

Defense attorneys historically counseled physicians to avoid saying "I'm sorry," assuming that a plaintiff's attorney would argue that the words were an admission of guilt. Dr. Lucian Leape, Professor of Health Policy at Harvard Medical School, has this to say about that assumption:

> For decades, lawyers and risk managers have claimed that admitting responsibility and apologizing will increase the likelihood of a patient filing a malpractice suit and be used against a doctor in court if they sue. However, this assertion, which seems reasonable, has no basis in fact. There is to my knowledge not a shred of evidence to support it. It is a myth.[4]

In fact, there is good evidence "…that instead of increasing lawsuits and awards to patients, apologies actually reduce both the incidence of lawsuits and the amount of awards. Evidence from multi-year studies at both the Veterans Administration Hospital of Lexington, Kentucky, and University of Michigan Health support this conclusion."[5]

Disclosing Unanticipated Medical Outcomes (DUMO) is the moral and professional expectation of groups such as the American Medical Association, The Joint Commission, the American Academy of Physicians, the National Patient Safety Foundation, and the National Quality Forum. Understanding how to make a disclosure compassionately and successfully takes planning and thoughtfulness.

Do you feel prepared and capable of communicating the difficult message of an

4 Leape, Lucian, MD, "Full Disclosure and Apology—An Idea Whose Time has Come," *The Physician Executive*, March-April 2006, p. 17.

5 Tabler, Norman G., "Dealing with a medical mistake: should physicians apologize to patients?" *Medical Economics*, November 10, 2013.

unanticipated medical outcome in a manner that preserves the physician-patient relationship? When an unexpected outcome takes place, an empathetic discussion explaining what happened can help prevent a negative patient response and can actually improve patient trust and reduce the risk of a malpractice suit. This year, resolve to participate in some disclosure training. For more information, contact Loss Prevention at 510/428-9411, extension 3348, or email lossprevention@miec.com.

6 *Resolution 6: I will consistently educate patients and document my efforts.*

When patients are inadequately educated about their medical condition, treatment, medication, and/or follow-up, their lack of information may contribute to noncompliance, misunderstanding, disappointment, and/or injury resulting in an inclination to litigate. Too many physicians rely upon oral communication alone, which may easily be forgotten. Health literacy and limited English proficiency (LEP) issues also contribute to miscommunication. This year, resolve to consider what you communicate and how. Take time to ensure patient understanding. Dispense written information about diseases or conditions you treat, drugs you prescribe, and about self-care and follow-up. Use resources such as The eXchange (www.health-exchange.net) to communicate with your LEP patients and document that this information was dispensed.

Consider the benefits of "shared decision-making," an educational strategy where "patients and providers together consider the patient's condition, treatment options, the medical evidence behind the treatment options, the benefits and risks of treatment, and patients' preferences, and then arrive at and execute a treatment plan. The strategy is often used with patients who have 'preference-sensitive' conditions or treatment options—that is, they may or may not choose particular treatments, or to be treated at all, depending on their own feelings about the risks versus the benefits of treatment, their ability to live well with their conditions, or other factors."[6]

As with patient education in general, employing various modalities to enhance the conversation can be beneficial. Use decision aids, such as videos, pamphlets, websites, and other interactive media to give patients information about the risks and benefits of treatment options so that they can make a decision that most reflects their personal values. Organizations such as the Informed Medical Decisions Foundation (www.informedmedicaldecisions.org) and the private company Health Dialog, have developed balanced, expert-reviewed decision materials. Effective patient education leads naturally to **Resolution 7...**

6 James, Julia, "Health Policy Brief: Patient Engagement. People actively involved in their health and health care tend to have better outcomes—and, some evidence suggests, lower costs," *Health Affairs*, February 14, 2013.

7 *Resolution 7: I will obtain informed consent effectively and document the discussion.*

Many surgical and medication management cases include a secondary allegation of "failure to obtain informed consent" in which a patient alleges that the risks of the procedure and other elements of the informed consent discussion were not adequately explained. You have an uphill battle to prove that you obtained informed consent if you did not document it properly. Informed consent is a process by which the patient gives consent to the doctor after (1) the physician has explained the purpose of the treatment or test, its benefits and risks, alternatives and their risks, and

the expected outcome; (2) answered the patient's questions the physician (not a staff member) has; and (3) the patient gives his or her consent to proceed. Consent forms complement, but do not replace, the informed consent discussion. A hand-written or dictated note about the consent discussion is more helpful in defending you than is a signed form, even in states in which a consent form is prima facie evidence of consent given.

Informed consent discussions documented in pre-operative consultation reports or progress notes or in H&Ps are more protective than those documented in operative reports or procedure notes, which are usually created after the procedure and inevitably appear to be self-serving if a surgical complication occurs.

Conversely, patients have the right to decline hospitalization, referral to specialists, or other recommended treatment. In California, a Supreme Court decision obliges physicians to explain the possible risks or consequences of the patient's choice to decline or refuse a physician's recommendation. Only after the patient has been given this information can it be said the patient has given an "informed refusal." The discussion and refusal should be documented. Although physicians in other states are not obligated by the California decision, we recommend that you document those discussions as evidence that the patient was given adequate information with which to make an informed refusal decision.

8 *Resolution 8:* *I will discuss advance care planning (ACP) with my patients and their families.*

As America's patient population continues to age with more Americans age 65 and older than at any other time in history (*US News and World Report*, January 9, 2012), physicians are faced with the challenge of guiding patients and their families through some very difficult decision-making about treatment options, understanding mortality and morbidity, pain management, and realistic expectations about outcome. This type of conversation takes time and is most beneficial when carried out by a physician. However, staff participation in the ACP conversation is valuable if staff has been trained to properly and compassionately discuss decisions with your patients. Patients and families trust you and need your counsel at the end of life perhaps more than at any other time throughout the physician-patient relationship. An added benefit: starting in 2016, CMS will pay Medicare providers for an initial 30- minute conversation and an additional 30-minute follow-up discussion. Ensure that your coding staff know the new CPT codes to ensure reimbursement.

This year, as part of your efforts to educate patients, resolve to communicate with patients and their families about their end-of-life concerns. Train staff how to participate in this vital patient education. Gather resources to enhance patient understanding (e.g., videos, written materials). Some local resources include:

Medical societies: All of the medical executives of the societies who work with MIEC agree that the challenge is to get the message out to both physicians and patients about ACP. Contact your local medical society. To name a few in California:

- Alameda–Contra Costa Medical Association (ACCMA) has developed a coalition with more than 100 organizations in the

community (visit www.eastbayacp.org).

- San Francisco Medical Society (SFMS) developed The San Francisco POLST Coalition, which has been in place since at least 2011.
- Napa and Solano Counties Medical Society reaches out to the community through Partnership Health Plan and local hospice programs.
- Marin Medical Society (MMS) supports an ACP community coalition. MMS has supported and aided the distribution of the POLST forms; educated physicians (members and nonmembers) on the issues and amendments to the "right to die" legislation recently signed by Gov. Brown; and made plans to co-host a physician education forum or workshop in 2016 with public health on ACP.

Third-party payers: In Hawaii, the HMSA partnered with Harvard Medical School physician and researcher Angelo Volandes, MD, a co-founder of the nonprofit foundation ACP Decisions, whose mission is "to empower patients, along with their families, to participate in their own healthcare," using culturally sensitive videos to help physicians and patients have these difficult conversations (visit www.acpdecisions.org for more information).

9

Resolution 9: *I will re-evaluate how I can use my electronic health record more effectively.*

There continue to be numerous advantages to documenting electronically versus the traditional paper chart. Most systems allow you to e-Prescribe and manage medications; discover known allergies or contraindicated medications; simplify follow-up on ordered labs or referrals; develop documentation tools for easy record-keeping; and to facilitate access to co-treaters' records. Systems should enable you to document for "value-based reimbursement," "meaningful use," PQRS quality, and ACO shared savings, and help you to transition from ICD-9 to ICD-10 codes.

To date, liability risks associated with EHRs focus primarily on the misuse of the systems. Some examples: failure to document completely or accurately because the physician was not familiar with all the EHR's record-keeping features; overstating what occurred during an office visit (e.g., "cloning" office visits, or documenting normal exams with details beyond what occurred during the actual visit for the purpose of billing at a higher level); and documenting by exclusion.

The advantages of EHRs far outweigh their disadvantages. When used effectively, an EHR will assist you in your efforts to document your medical decision-making, judgement and management of patients' care, ultimately providing evidence that you practice safe, quality medicine and comply with the standards of care. For current information on the top EHRs, look to resources such as Medical Economics' 2015 EHR Report Card and KLAS Research.

10

Resolution 10: *I will document significant telephone communication with my patients and my colleagues' patients when I am on call.*

Some of MIEC's most costly paid claims involve physicians' failure to document conversations with patients while on call. Significant losses have resulted when patients suffered catastrophic injury deemed to be the result of a telephone

communication in which an on-call physician allegedly failed to advise the patient to go to the ED or to take definitive steps to avoid injury. In these cases, MIEC's claims representatives and defense attorneys were confident that the on-call physicians gave appropriate advice to the patients. However, the lack of documentation memorializing the conversations made it impossible to prove.

This year, develop a method for documenting these vital conversations. Dictate a note immediately after the telephone call (date and time the call). Call your office voicemail or call services with a reminder to document the call. Use your cellphone memo function. If you have an EMR, create a contemporaneous note that includes what a patient communicated to you; advice you gave; evidence of patient understanding; and any indications whether or not the patient intends to comply with or refuse your advice. If covering for a colleague, ensure that the documentation is promptly forwarded to the patient's treating physician.

If any one of us at MIEC can be of service, please do not hesitate to call. Historically, we've partnered with policyholders to keep your premiums low and this year, as we enter a new decade, we will continue to assist you in your efforts to promote patient safety while you increase patient satisfaction and decrease your liability.

Allegations by specialty and the precipitating injuries

Cardiovascular surgery: Most of MIEC's high-indemnity cardiovascular surgery claims have dealt with negligent performance of a CABG; aortic root replacement; wrong site surgery; post-operative medication (anticoagulation) mismanagement; and negligent treatment of saddle embolus resulting in death.

Emergency medicine: Failure to diagnose dissected aortic aneurysm resulting in death; failure to diagnose stroke; failure to diagnose meningitis, infection or subdural hematoma.

Gastroenterology: Negligent performance of colonoscopy resulting in perforation; negligent ERCP; failure to diagnose colon cancer.

General surgery: Aside from procedures found to be improperly performed, we've handled numerous claims involving miscommunication between members of the treating medical team that resulted in mismanagement of patient care and severe injury.

Hematology/Oncology: Negligent infusion/administration of chemotherapy resulting in extravasation; failure to diagnose and treat thrombotic thrombocytopenic purpura.

Hospital medicine: Failure to diagnose stroke; failure to diagnose pancreatitis; failure to diagnose and treat herniated diaphragm.

Neonatology: Failure to diagnose and treat hyperbilirubinemia resulting in severe injury or death; failure to diagnose and treat pneumothorax; failure to timely diagnose persistent hypertension resulting in cardiopulmonary arrest and brain damage.

Neurosurgery: Negligent laminectomy/discectomy resulting in paraplegia, nerve root injury, leg weakness; in at least three high-indemnity cases, experts questioned the approach chosen (posterior vs. anterior); failure to diagnose and treat papilledema, damaged vision; surgery at wrong spinal level; misdiagnosis of glioma resulting in unnecessary brain surgery.

Pain management: Improper performance of interventional procedures (e.g., overly aggressive management — multiple levels), resulting in long term injury; mismanagement of narcotics, specifically, overdose via Fentanyl patches.

Pediatrics: Negligent treatment of encephalitis resulting in death.

Plastic surgery: Aside from procedures found to be improperly performed, we've handled numerous claims in which poor post-operative management resulting in injury was alleged.

Primary care: Mismanagement of chronic conditions, such as diabetes and hypertension, resulting in permanent injury; failure to diagnose and treat cancer or impending stroke.

Radiation oncology: Excessive/over radiation to the brain.

Radiology: Failure to diagnose cancer (breast, lung, colon); incorrect level identification by X-ray; delay in diagnosis of stroke.

Table 1

Prevent the spread of infections*

- HAND HYGIENE IS THE MOST IMPORTANT ACTIVITY THAT CAN BE PERFORMED TO PREVENT INFECTIONS! Be a role model for your practice!
- When hands are visibly soiled, before and after eating, and before and after using the restroom, hand washing with soap and water is best. Scrub for 15 seconds, or the amount of time it takes to say the alphabet. Alcohol-based hand sanitizer can be used for other contacts.
- Assure that physicians and all employees practice hand hygiene before and after touching patients or using equipment that touches patients. Hand hygiene should be regularly monitored in the office. Staff can be assigned to take turns being the "monitor" for a day to observe co-workers. Observations should be shared.
- Use gloves, gowns, goggles or protective glasses, and face shields as needed to prevent exposure to blood and bodily fluids. Hand hygiene is required after these are removed.
- Disposable patient care items should be removed from exam rooms between patients and placed in regular trash, with the following exception: Items that are saturated with blood or bodily fluids must be placed into biohazardous waste containers.
- Medical office surfaces that are frequently touched should be cleaned regularly with germicide. Patient care items that contact skin must be cleaned with germicide after each use. Items that come into contact with open skin and mucous membranes must be sterile.
- Cover cuts and other open wounds to prevent secondary spread.
- Medications should be stored safely, and temperatures must be monitored daily.
- Assure that syringes and needles are used only once per patient and disposed of properly.
- Activate safety mechanisms and dispose of sharps in the sharps container immediately after use to prevent needle stick injury.
- Provide signs promoting respiratory hygiene. Place supplies in the waiting area: tissue, masks, hand sanitizer, and trash receptacles. Patients with respiratory symptoms should be roomed as soon as possible.
- Educate your patients about the diseases and their prevention, including good hand hygiene and respiratory hygiene practices for the home.

* Our thanks to Linda Onstad, RN, CIC, Infection Control, at Eden Medical Center in Castro Valley, California for her assistance with Table 2. Reprinted from 2010.

Table 2

Underwriting Corner

Enhanced DataGuard coverage

Effective February 1, 2016, MIEC will be providing policyholders with an expanded coverage (DataGuard endorsement). Since the 2012 policy year, MIEC policyholders have been provided DataGuard (also known as the Information Security Endorsement) and were initially offered coverage for loss due to disclosure of confidential information or damage to information systems.

MIEC offers this coverage in collaboration with NAS Insurance, a specialist in cyber liability products. NAS provides underwriting and claims support to MIEC in the administration of the DataGuard product. More information on NAS can be found at www.nasinsurance.com.

Basic limits of coverage offered are $50,000 per occurrence and in the aggregate; defense costs are included within the limit. The expanded DataGuard coverage cost remains $60 per policy for all policies except healthcare facilities. Excess limits are available for any policyholder. Contact your underwriter or visit MIEC's website at www.miec.com. Find an application under the Resources tab, click Applications & Forms and then click on MIEC Policy Forms http://www.miec.com/RESOURCES/APPLICATIONSFORMS/tabid/83/Default.aspx#policy.

The previous DataGuard Coverage Agreements were as follows (by coverage part):

A. e-MD™ Network Security and Privacy
B. Regulatory Fines and Penalties
C. Patient Notification and Credit Monitoring Costs

D. Data Recovery Costs

The newly expanded DataGuard coverage includes the following insuring agreements:

A. Multimedia Liability (NEW COVERAGE)
Coverage for claims alleging copyright/trademark infringement, libel and slander, plagiarism, or personal injury resulting from dissemination of media material.

B. Security and Privacy Liability
Coverage for claims alleging liability for a security breach or privacy breach. While not a new coverage of the DataGuard endorsement, this coverage component no longer includes defense of governmental actions, as defense of governmental actions is now included within a separate, broader privacy regulatory insuring agreement (Coverage C below).

C. Privacy Regulatory Defense and Penalties (EXPANDED COVERAGE)
This coverage was also included in the original DataGuard endorsement; however, the coverage has been restructured into a new insuring agreement for the defense of governmental actions resulting from a security breach or privacy breach, and fines or penalties resulting from such actions. Coverage now also extends to regulatory compensatory awards to affected individuals.

D. PCI DSS Assessment (NEW COVERAGE)
Coverage for claim expenses and assessments and fines imposed by banks and credit card companies due to noncompliance with the Payment Card Industry Data Security Standard (PCI DSS) or payment card company rules.

E. Privacy Breach Response Costs, Patient Notification Expenses and Patient Support and Credit Monitoring Expenses

Expanded from coverage under the initial endorsement, the addition explicitly includes the costs for a public relations consultant to mitigate reputational harm resulting from an adverse media report. It also includes proactive privacy breach response costs — public relations expenses incurred prior to the publication of an adverse media report in an effort to avert or mitigate the potential impact of such an adverse media report on the insured's reputation. Coverage for voluntary notification expenses is now also included under this Section, which insures the expenses incurred in notifying individuals of a security breach or privacy breach where there is no requirement by law to do so.

F. Network Asset Protection (EXPANDED COVERAGE)
This coverage was also included in the original DataGuard endorsement (as "Data Recovery Costs") and has been expanded to include income loss, interruption and special expenses resulting from accidental damage or destruction of electronic media or computer hardware, computer crime or cyber-attacks, or administrative or operational mistakes in the handling of the Insured's electronic data or computer system.

G. Cyber-Extortion (NEW COVERAGE)
Coverage for extortion expenses incurred and extortion monies paid as a direct result of a credible cyber-extortion threat.

H. Cyber-Terrorism (NEW COVERAGE)
Coverage for income loss, interruption and special expenses resulting from a total or partial interruption of the insured's computer system caused by

an act of cyber-terrorism.

I. **BrandGuard™ (NEW COVERAGE)** Coverage for lost revenue resulting from an adverse media report of a security breach or privacy breach or breach notification.

The new DataGuard endorsement wording can be found on the MIEC website under the Policyholder Services tab, in the Underwriting section, then you click Policies and Endorsements, log-in required **http://www.miec.com/POLICYHOLDERSERVICES/PoliciesEndorsements.aspx**.

For additional information on DataGuard, please contact your underwriter at MIEC. Visit www.miec.com > DataGuard Coverage >"Explore these tools here" for online training and template resources. Access to the resources will require policyholder log-in.

Claims Corner

Blevin v. Coastal Surgical Institute:

Be careful with revisions, reimbursements and write-offs! They could impact your claims resolution

(California only)

By Renee A. Richards, Esq.
Hassard Bonnington LLP, San Francisco, CA

So you have a patient who is not happy with the procedure you just performed—what now? Perhaps you have thought about paying her claim for lost wages due to a longer-than-expected recovery period following a complication, or waiving the amount she still owes you, or arranging for her to consult with another specialist at your expense before she hires an attorney. Before doing any of these things, remember to contact MIEC to discuss your patient's complaint and the different ramifications of settling a matter with an unrepresented patient.

It's important to know that in early 2015, a California Court of Appeal held that any payment to an unrepresented patient in satisfaction of a medical negligence claim, or potential claim, must be accompanied by *a written statement about the applicable statute of limitations*, [California Code of Civil Procedure (CCP) §340.5]. Under *Blevin v. Coastal Surgical Institute* (2015) 232 Cal.App.4th 1321, if no such written statement accompanies a payment, and the patient does not sign a release barring further action on a claim, the one-year statute of limitations period under §340.5 will be tolled (extended) for up to three years pursuant to California Insurance Code §11583. (**Note:** The court said only the one-year statute of limitations could be tolled; the three-year outside limit is the mandated outside limit per MICRA and therefore, any tolling of that limit would require a legislative change.)

Blevin case background

Respondent Charles Blevin had knee surgery at Coastal Surgical Institute on September 1, 2010. He later developed a post-operative infection that was traced to a disinfecting sponge used to clean surgical equipment. The sponge manufacturer was sued, along with the surgical facility.

On October 12, 2010, Coastal Surgical

paid Blevin—who was not represented by counsel—$4,118.23 for medical expenses he claimed to have incurred as a result of the infection. Blevin did not sign a release, nor was he given any written notice of the applicable statute of limitations for his potential medical negligence claim. Fifteen months later, he filed a medical malpractice case against the surgery center, and later amended his complaint to name the sponge manufacturer, who settled for $100,000.

Coastal Surgical argued to the trial court that Blevin case was barred by the statute of limitations, because he had filed his suit more than one year from the date he discovered the injury and made a claim for compensation. The trial court disagreed and ruled the action was timely; the one-year limitations period for medical negligence actions in CCP §340.5 was extended because the $4,118.23 payment to Blevin was made without written notice of the limitations period as required by Insurance Code §11583. In a special verdict, the jury found Coastal Surgical negligent and awarded damages to Blevin in excess of $500,000, which the court reduced to $285,114; Coastal Surgical appealed.

The Court's analysis

California Insurance Code §11583 states, in pertinent part:

> *No advance payment or partial payment of damages made by any person, or made by his insurer…, as an accommodation to an injured person…shall be construed as an admission of liability by the person claimed against, or of that person's or the insurer's recognition of such liability….Any person, including any insurer, who makes such an advance or partial payment, shall at the time of beginning payment, notify the recipient thereof in writing of the statute of limitations applicable to the cause of action which such recipient may bring against such person as a result of such injury….Failure to provide such written notice shall operate to toll any such applicable statute of limitations or time limitations from the time of such advance or partial payment until such written notice is actually given. That notification shall not be required if the recipient is represented by an attorney.*

The appellate court explained that the policies behind the tolling provisions of §11583 are intended to both encourage early payment of a claim without fear of admitting liability, and prevent an injured person from being "lulled into a false sense of complacency about the need to sue because an advance or partial payment by the defendant or their insurer shows their apparent cooperativeness." Because Coastal Surgical paid Blevin, an unrepresented patient, for his injury claim without getting a release or providing written notice of the applicable statute of limitations, the court held Blevin lawsuit was timely, even though it was filed more than a year after he discovered his injury and made his initial claim.

Coastal Surgical contended that the insurance code's tolling provisions do not apply to medical malpractice actions subject to the MICRA limitations periods embodied by CCP §340.5. The appellate court disagreed. The underlying facts were undisputed—Blevin was injured, was unrepresented, received payment for his expenses by appellant, did not sign a release, and was not notified by appellant in writing about the applicable medical malpractice statute of limitations. In addition, since there is no state of mind or intent requirement in §11583, it did not matter whether the parties considered

the $4,118.23 payment to be full or partial satisfaction of Blevin's potential claim. "In cases of this kind where there is no conflict in the evidence upon which the determination of a question of law rests the decision is for the court and it should not be submitted to the jury. (Citations omitted.) Based on the undisputed facts, the trial court correctly decided that, pursuant to §11583, the one-year statute was tolled and therefore did not bar respondent's action."

To avoid extending the one-year limitations period of §340.5, the court explained that "Section 11583 requires no more than that the payor notify the payee in writing of the applicable statute of limitations, **not the actual expiration date**. Thus, it would have been sufficient if appellant had informed respondent in writing of the three-year and one-year periods as provided in Section 340.5." (Emphasis added.)

How does *Blevin* affect your practice?

Physicians and insurers should be aware of the Blevin's, decision and its potential impact on claims resolution. Insurance Code §11583 specifically applies to "any person" or his or her "insurer," so individual physicians as well as their professional liability carriers fall within its provisions. Further, payment of money is not the only method of claims resolution that could be considered a "payment" for purposes of Insurance Code §11583; any payment or service of monetary value that is offered in full or partial satisfaction of the patient's claim could be considered a "payment." The following two cases are illustrative.

The provision of a single counselling session in response to a personal injury claim has been held to be a "payment" that triggers the tolling provision. In *Doe v. Doe* (2012) 208 Cal.App.4th 1185, an unrepresented parishioner was given one session of counselling, paid for by the church, after he alleged he had been molested. No written notice of the applicable statute of limitations was given by the church to the claimant. The appellate court held that, under §11583, payment for one counselling session was sufficient partial payment on a claim for damages to toll the statute of limitations on his molestation claim.

In *Maisel* v. *San Francisco State University* (1982) 134 Cal.App.3d 689, the appellate court said it was possible the provision of medical care to a student injured by equipment in the school's fitness center could be considered a "payment" for purposes of triggering the tolling provision of §11583. The record was clear that claimant was provided coverage for basic medical care as part of his tuition. What was not clear from the record was whether the specialized care required to treat his injury was considered part of the basic student coverage included in the cost of tuition, or whether it would be part of a higher level of coverage made available to students for an additional fee. If the specialized care rendered was not contemplated or covered by the basic plan, and the claimant was given but not charged for the higher level of coverage, it would be considered a "payment" for purposes of triggering the tolling provisions of §11583. The case was sent back to the trial court for determination of this fact.

In a nutshell:

Since *Blevin*, we are of the opinion that:

- any payment on a claim;
- waiver of amounts owed for care;
- referrals to other care providers that are arranged and paid for by the referring physician; or,
- the rendition of additional care at no charge to an *unrepresented* patient would all be considered a "payment" for purposes of triggering the extension of the one-year statute of limitations.

The claimant must be given written notice of the limitations period; otherwise, one risks extending the one-year statute for up to three years.

Contact MIEC's Claims Department

For these reasons, before any resolution of a claim is undertaken, it's important to let MIEC know about the claim and what it involves. In addition to the considerations about applicable limitations periods with which the Claims Department will be familiar, there may be provisions in your liability policy that require MIEC be given notice of a claim as soon as you become aware of it.

We acknowledge there are circumstances in which an informal resolution with a patient seems appropriate—such as offering additional care or a revision surgery at no cost in response to a patient's dissatisfaction with a particular outcome. However, physicians need to consider the likelihood that such additional care—if rendered at no cost to the patient—could be considered a "payment" for purposes of §11583. **It's important not to attempt to resolve a patient complaint in this manner without contacting the Claims Department ahead of time; doing so might risk coverage, result in a payment being made on a claim that may not fully resolve the matter, and also extend the time within which the patient can file a malpractice action.**

Have patients sign a release

As counsel for MIEC, we advise physicians to have patients sign releases when a "payment" is made. A release will protect you from any further action on the patient's claim. If, after consultation with MIEC, one is not inclined to ask a patient to sign a release, at the very least, any "payment," as discussed above, should be accompanied with a written notice of the limitations period. Bear in mind, though, that without a release, even partial (or full) payment with written notice of the limitations statute will not prohibit plaintiff from suing within the limitations period, and no credit for payments made will be available should plaintiff be successful in court.

Finally, when discussing complaints with your patients, you may want to express feelings of sympathy or empathy, and acknowledge a less-than-ideal outcome, while reassuring the patient that you will do your best to remedy the situation.

Patients appreciate an open line of communication with their healthcare providers as well as having their feelings acknowledged and complaints heard. However, it is essential that such an expression of sympathy or empathy not be expressed as an admission of liability. An expression of sympathy is not admissible as evidence of liability should the case go to court whereas an admission of fault is. MIEC Loss Prevention and Claims staff can offer guidance on early disclosure and expressions of empathy and sympathy with your patients. See also The Exchange, Issue 6, published by MIEC in April 2015 and available here: http://www.miec.com/Portals/0/TheExchange/TheExchange_Issue6.pdf.

Questions?

The following are a few scenarios physicians might encounter. Remember, if you have a patient who is unhappy and you may be facing a claim, please contact MIEC for advice right away, because each situation is different. The following Q and A's are meant to be examples only, and should not be taken as legal advice in your particular situation.

My patient is unhappy with the scarring from a mole removal procedure. Can't I just attempt to revise the scar without charging the patient and making a big deal about it?

You could, but remember that under *Blevin* any additional procedure performed at no cost to an unrepresented patient in response to his or her complaint could, for purposes of extending the statute of limitations on the original procedure, be considered a "payment". In addition, any new procedure would have its own timeline for purposes of calculating the limitations period. If you are facing a situation like this, please contact MIEC to ask for suggestions about what to do.

I've decided to waive the amounts my patient owes me since he said he was not happy with my treatment and is not going to pay me anyway. It's not that much money, and I'd rather just waive the outstanding bill rather than deal with sending it to collections and angering him further. Can I do that?

Yes, you can, but remember that waiving of fees owed to you could be considered a "payment" under the *Blevin* decision since you are essentially giving the patient something of value in response to a complaint about services rendered. Call MIEC to seek assistance in writing a letter to the patient that can reference your waiver of the fees and the applicable statute of limitations without admitting liability.

I'm an anesthesiologist, and once in a while a patient will sustain some slight dental damage as a result of having been intubated during a long procedure. I have been referring these patients to a colleague who is a dentist and paying for that care myself. Under Blevin, could this be considered a payment on a claim that might extend a statute of limitations on any claim a patient could have against me?

Yes, the costs of referral to another healthcare provider for the provision of services at your expense would be considered a payment for purposes of *Blevins* and §11583. See the discussion about the *Doe v. Doe* case above.

I am a plastic surgeon, and part of my agreement with my patients is that the cost of some procedures (for example, rhinoplasty) is a flat fee that anticipates and includes minor revisions in order to make sure the patient is happy with the result. Will this trigger the tolling provision of Insurance Code §11583?

A It's possible that a flat-fee, prepaid plan for a procedure or series of procedures may not trigger the tolling statute, as long as you have a clear agreement with patients that this is how your office does business. However, some patients might wonder why you are requiring up-front payment for anticipated revisions at the time you are contracting for the original surgery. In addition, it's important to remember that each time you do a new procedure, that procedure may have its own limitations period. In other words, even though it may be paid for as part of the original procedure, a new surgical procedure like a rhinoplasty revision would be considered a new surgery for purposes of the statute of limitations and the patient's discovery of a claim on that procedure. Finally, one cannot rule out the possibility that a court could view such a prepaid plan as a method of trying to subvert §11583.

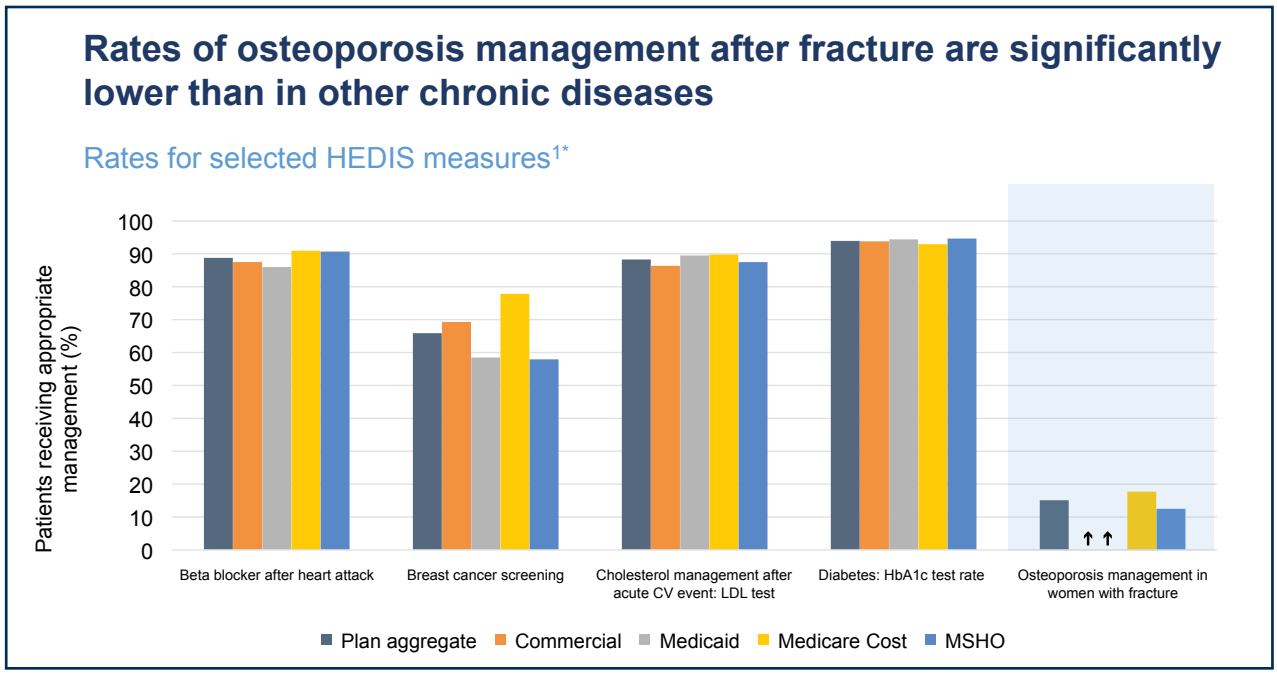
Calling All Orthopedists: Look Beyond the Fracture

By Kathleen M. Cody, Executive Director
American Bone Health

As we enter the winter months, falls and fractures become a common occurrence. It's dark outside, and walkways can be slippery. What we don't often think about is that a fracture can be a sign of an underlying bone health problem in adults over age 45. Even if the fracture is a result of a fall, it is always good practice to look beyond the obvious fracture. Orthopedic surgeons have a unique opportunity to help champion the cause of bone health.

There are 2 million preventable fractures every year that cost the healthcare system $20 billion. Hip fractures account for about 15% of the total, and an estimated 75,000 patients die from complications within a year. Nearly half of all women who have hip fractures had a previous fracture that should have signaled aggressive fracture prevention strategies.

As the population ages, the fracture statistics will only get worse. By 2025,



estimates are that preventable fractures will grow by 50%. Secondary fracture prevention has caught the eye of our health plan accrediting agencies and the Centers for Medicare and Medicaid Services (CMS) in light of how fracture patients fare when compared to patients who are managed for other chronic conditions.

Osteoporosis or low bone density is often a contributing factor to fractures, yet clinical management of post-fracture patients barely exists. The National Committee for Quality Assurance (NCQA) tracks the percentage of women age 65 and older who have had a fracture and if they had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture. In the Medica® Clinical Performance Measures Report of 2012–2013, fewer than 20% of fracture patients were evaluated or treated for the underlying cause of the fracture. Compare those results to the treatment of patients with other chronic diseases.

Healthcare performance measures are now in place to help improve clinical management of fractures. The Physician Quality Reporting Set (PQRS) established by CMS includes the following measures that are also endorsed by the American Medical Association (AMA), the Physician Consortium for Performance Improvement (PCPI), and NCQA:

- Osteoporosis: Communication with the physician managing ongoing care post-fracture of hip, spine, or distal radius for men and women aged 50 years and older (PQRS measure #24) (AMA-PCPI/NCQA)
- Screening or therapy for osteoporosis for women aged 65 years and older (PQRS measure #39) (AMA-PCPI/NCQA)
- Osteoporosis: Management following fracture of hip, spine, or distal radius for men and women aged 50 years and older (PQRS measure #40) (AMA-PCPI/NCQA)
- Osteoporosis: Pharmacologic therapy for men and women aged 50 years and older (PQRS measure #41) (AMA-PCPI/NCQA)
- Falls: Screening for future fall risk (PQRS measure #318) (AMA-PCPI/NCQA) Patients who have had one fracture are at increased risk for having additional fractures.

Unlike many other chronic conditions, the clinical management of bone health for most fracture patients is not complicated.

1. Diagnose the patient with osteoporosis (ICD-10 Code M81.0).
2. Order a bone density test [preferably dual-energy X-ray absorptiometry (DXA), if not conducted in the last 2 years] for diagnostic use and as baseline for monitoring change over time.
3. Determine fracture risk using the FORE FRC or FRAX tool and treat if appropriate.
4. Rule out and/or treat secondary causes for active bone loss, if not done previously.
5. Optimize bone health nutrition:
    - Ensure calcium from diet and supplements in the 800–1,200 mg/day range.
    - Maintain Vitamin D range between 30 and 45 ng/mL.
    - Encourage 5-6 ounces of protein from food daily.
6. Prescribe ancillary support services to increase exercise and physical activity,

and minimize falls and future fractures:

- Physical therapy to focus on strength, balance, and posture.
- Occupational therapy to address fall prevention and proper body mechanics.
- Home health visits to reduce fall hazards and review compliance with therapy.
- A back brace (e.g., Spinomed) can help with back pain and improve body mechanics in patients with vertebral fractures or kyphosis.

7. Consider fall risk by reviewing falls history, assessing risk, and documenting an appropriate management plan for patients at risk.

In particular, members of the orthopedic community can help us close the gap in post-fracture patient care. We must educate patients about bone health during their fracture healing process when they are thinking to themselves "I never want this to happen again." If we wait until the pain and disability subsides, the patient's sense of urgency about bone health is often lost to other priorities in life. In fact, many patients never tell their primary care doctor that they broke a bone.

We all have a role to play in bone health —patients and providers alike. Let's not let a fracture be the end event—let's make it the beginning of bone health and prevent secondary fractures.

CRICO Corner

Communication Breakdowns Drive Diagnostic Failure in Emergency Medicine

As reported in *ImproveDx*, the newsletter of the Society to Improve Diagnosis in Medicine, CRICO Strategies reviewed more than 10,000 cases, asserted between 2004 and 2008. Eight hundred seventy-two (872) were ED claims of which more than half (479) alleged diagnostic failures; such failures cause the most frequent and costly claims against emergency departments.[7] Surprisingly, researchers found that the missed diagnoses were not unusual presentations or rare diseases. Rather they were straightforward conditions such as myocardial infarctions, fractures and gastrointestinal issues. According to CRICO Strategies Program Director Gretchen Ruoff, missed diagnoses were "... happening to healthy patients with uncomplicated histories, and we had significant issues with clinical judgment and communications. We weren't getting all the right information, we were focused too narrowly and taking the patient down the wrong pathway, sending them out the door oftentimes with something very dangerous."[8]

In response to this initial finding, in 2010, CRICO and CRICO Strategies convened the Emergency Medicine Leadership Council (EMLC) to take a closer look at 200 of the 479 failure to diagnose emergency claims. The Council found that missed or delayed diagnoses were frequently due to missing information, data that had been gathered at the time of the ED visit but unavailable to the treating physicians for a variety of reasons. In 2011 EMLC reported its findings in a white paper. Possible information gaps included:

1. The availability of prior historical information from the medical record or referring physician;

7 Carr, Susan, "Communication Breakdowns Drive Diagnostic Failure in Emergency Medicine," *ImproveDx*, Volume 1, Number 1, January 2014 www.improvediagnosis.org.

8 Ibid.

2. A change in the patient's status or a persistent abnormal vital sign;
3. The timeliness of laboratory or radiology data;
4. Communication from the consultant physician;
5. Miscommunication at patient hand offs; and,
6. Barriers to effective communication between the nurse and physician caring for the patient.[9]

Based upon the gaps identified, the EMLC developed a self-assessment survey which the Council's members used at their own hospitals to better understand if and how these information gaps impacted outcomes at their facilities and to explore opportunities for improvement such as diagnostic timeouts, physician-nurse huddles, trigger alert systems, vital sign audits, team training, and simulation exercises.[10]

9 Ibid.

10 Ibid.

MIEC and ED Groups Conduct a Self-Assessment

Inspired by CRICO Strategies' work to help emergency physicians decrease the occurrence of diagnostic errors (MIEC's primary allegation for ED claims and suits), MIEC partnered with CRICO Strategies to help MIEC ED policyholders conduct the EMLC's self-assessment survey. Half of MIEC's insured ED groups participated in the survey. Some of the responses came primarily from group leadership while others asked all members to contribute their responses to the survey. Five categories of information voids were surveyed: access to historical information; adequacy of real-time clinical assessments; integration of diagnostic test results; consultations; and effective teamwork and communication.

In the late Fall 2015, MIEC and CRICO Strategies reported the survey outcomes to the six participating groups in the form of a webinar. Groups received their individual results by email. The following are the cumulative results from the contributing ED groups (1 = Needs Improvement and 5 = Best Practices):

- **Access to historical information:** The greatest challenge for the majority of the respondents was obtaining historical data from primary care and/or referring physicians – information from outside the ED or hospital.

CATEGORY / ISS UES	HIGH SCORE	LOW SCORE	AVERAGE SCORE
From PCP	3.0	1.0	2.2
From referring MD	4.0	1.0	3.0
From recent ED visits	5.0	4.6	4.7
Access to medical record	5.0	2.9	3.6

- **Adequacy of real-time clinical assessment:** Although the average score in this category was 3.3 to 3.7, respondents' comments reflected concerns with inefficiencies of the electronic charting system and communication breakdown between nurses and physicians in reconciling vital signs and abnormal test results. In some instances, information might be available but difficult to locate in the EHR, or there is limited communication between team members.

CATEGORY / ISSUES	HIGH SCORE	LOW SCORE	AVERAGE SCORE
Effectiveness of/attention to initial triage information	4.2	3.1	3.7
Communication of status change/response to treatment	3.8	2.7	3.4
Reconciliation of abnormal vital signs (including at D/C)	3.7	2.0	3.3
Reconciliation of abnormal findings/test results	4.4	2.0	3.7

- **Diagnostic testing and result management:** Overall, the surveyed group found diagnostic test result information timely and accessible with the average score ranging from 3.3 to 4.2. The greatest challenge appeared to be reconciliation of late or updated lab results after the patient has been discharged from the ED. Groups noted that it is difficult to obtain test results on weekends or holidays.

CATEGORY / ISSUES	HIGH SCORE	LOW SCORE	AVERAGE SCORE
Timeliness of radiology testing/results	5.0	3.5	3.9
Communication of radiology critical findings/values	5.0	3.5	4.2
Reconciliation of late/updated radiology results after D/C	4.0	3.1	3.5
Timeliness of lab testing/results	5.0	3.5	4.0
Communication of lab critical findings/values	4.4	3.5	4.2
Reconciliation of late/updated lab results after D/C	4.0	2.5	3.3

- **Consultation:** Common challenges reported with this category included minimal access to subspecialties or specialties not available at all, lack of timely response when a consult is requested, and difficult communication between ED and consultant.

CATEGORY / ISSUES	HIGH SCORE	LOW SCORE	AVERAGE SCORE
Availability of necessary consults	4.5	2.7	3.6
Responsiveness of consults	4.0	2.4	3.3
Effectiveness of consults	4.0	3.0	3.5

- **Effective teamwork/communication:** Survey responders (primarily physicians and not nurses) voiced concerns about computer-driven communication between physicians and nurses instead of verbal exchanges; interruptions of physicians which affect their ability to think through a working diagnosis; and handoffs.

CATEGORY / ISSUES	HIGH SCORE	LOW SCORE	AVERAGE SCORE
RN/MD collaboration during clinical care process	4.2	3.4	3.9
RN/MD collaboration during diagnostic processing	4.0	3.0	3.6
Team response to unstable patients	5.0	3.5	4.3
Effectiveness of electronic health record (IT)	3.6	1.5	2.8

CATEGORY / ISSUES	HIGH SCORE	LOW SCORE	AVERAGE SCORE
Effectiveness of patient handoffs—staff shift change	4.1	3.0	3.7
Effectiveness of patient handoffs—admissions	4.0	3.0	3.8
Effectiveness of patient handoffs—transfers	3.9	3.0	3.6

Recommendations for MIEC emergency physicians

CRICO Strategies' analysts found many opportunities for improved communication and teamwork in the MIEC self-assessment survey results and made recommendations based upon their findings. These included:

1. Consider implementing Communication Events.
   a. Routine huddles at shift and team changes
      i. Use the STOP or SBAR communication techniques
   b. Identify routine triggers and what should be communicated
   c. Develop diagnostic/discharge time outs using a check list
      i. Review historical and real-time data
      ii. Reconcile abnormal vital signs
      iii. Determine diagnosis and plan
      iv. Assign action for follow-up (post-discharge appointments, call-back on pending results)
2. Develop a simulation process.
3. Develop standards for consuitations that include timeliness, availability, communication, and specialty-specific guidelines.
4. Build a multidisciplinary team and strategies to improve team awareness, clinical communication, and accurate patient assessment. Consider TeamSTEPs.

MIEC thanks CRICO Strategies' Director of Patient Safety, Dana Siegel, RN, CPHRM, and Senior Program Director, Patient Safety Services, Penny Greenberg, RN, MS, for their guidance and valuable insight throughout this project.

Feds Publish Guide for Security of Mobile Devices

Healthcare providers increasingly use mobile devices to receive, store, process and transmit patient health information, yet many organizations have not implemented safeguards to ensure the security of patient data when caregivers use mobile devices in conjunction with an EHR system. The National Institute of Standards and Technology (NIST) and the National Cybersecurity Center of Excellence (NCCoE) have released a draft of the cybersecurity practice guide, "Securing Electronic Health Records on Mobile Devices" to assist organizations in mitigating their risk. You can download the guide here: https://nccoe.nist.gov/projects/use_cases/health_it/ehr_on_mobile_devices.

The guide was created to provide organizations with detailed instructions to implement security measures on mobile devices used by physicians to access an electronic health record (sending a referral containing a patient's information to another physician; sending an electronic prescription to a pharmacy, etc.) The guide features commercially available and open-source tools and technologies which are interoperable with commonly used IT infrastructure. It provides a framework for

best practices, whether your organization is configured for wireless, "cloud" access, or a virtual private network.

Although the guide is created for an audience of IT professionals and security engineers, all HIPAA-covered entities should be aware of the implications of allowing patient information to be accessed or stored on mobile devices, particularly in conjunction with an EHR, and should incorporate safeguards into their HIPAA risk analysis.

The risks are real: The Ponemon Institute reports 125% growth in the numbers of intentional attacks over a five-year period. Malicious hacks on healthcare organizations now outnumber accidental breaches (Fifth Annual Benchmark Study on Privacy and Security of Healthcare Data, Ponemon Institute, May 2015). Primary identified threats to confidentiality, integrity, and availability of patient information are identified in the guide as:

- A lost or stolen mobile device
- A user who
  - ✓ Walks away from logged-on mobile device
  - ✓ Downloads viruses or other malware
  - ✓ Uses an insecure Wi-Fi network
- Inadequate
  - ✓ Access control and/or enforcement
  - ✓ Change management
  - ✓ Configuration management
  - ✓ Data retention, backup and recovery

Resources are available to smaller organizations that do not employ IT staff. Physicians who use mobile devices in conjunction with "cloud computing" are encouraged to use a questionnaire developed by the Office of the National Coordinator for Health Information Technology (ONCHIT) to assess and hold accountable its service provider for the implementation of security controls. The three-page questionnaire (AKA Security Risk Assessment Tool) addresses vendor agreements, third-party application integration, personal or device authentication and authorization, data protection, security of data in transmission, monitoring and auditing, emergencies, and customer and technical support. Download the questionnaire here: **http://www.healthit.gov/providers-professionals/security-risk-assessment**.

Additional information about mobile device risk and the security of health information is available from the Department of Health and Human Services at **http://www.healthit.gov/providers-professionals/your-mobile-device-and-health-information-privacy-and-security**.

The website has a wealth of information, including information on creating a Mobile Device Policy. Organizations that decide to allow PHI on mobile devices should consider the following actions to protect information on mobile devices:

- Use a password or other user authentication
- Install and enable encryption
- Install and activate remote wiping and/or remote disabling
- Disable and do not use or install file sharing applications (Dropbox, Google Drive, etc.)
- Install and enable a firewall
- Install and enable security software
- Keep your security software up to date
- Research mobile applications (apps) before downloading
- Maintain physical control
- Use adequate security to send or receive information over public Wi-Fi networks
- Delete all stored health information before discarding or reusing the mobile device

Organizations considering allowing PHI on mobile devices need to assess the risks involved, enact appropriate safeguards, incorporate these into HIPAA Security policies and procedures, and provide adequate training to all staff.

How to reach MIEC

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