MIEC

The Exchange

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INSIDE

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MIEC Loss Prevention Department Is Changing Its Name After 40 Years of Service

News! News! News!

After 40 years as the Loss Prevention Department, led by giants in the field such as Jill Silverman, David Karp, and Judy Huerta, the MIEC Loss Prevention Committee decided to change its name to the Patient Safety & Risk Management (PSRM) Committee. The Committee's intent: to better reflect its focus and that of the Department, namely, to work closely with you to improve patient safety, promote quality care, and reduce your liability risk.

Effective immediately, when you need assistance from our Loss Prevention staff, contact MIEC's Patient Safety & Risk Management Department. Our team of Patient Safety & Risk Management experts look forward to providing you with valuable services and resources that include:

- **Office surveys** in which we review your record-keeping practices, office policies, and other factors that may increase your liability exposure.
- **Seminars and webinars** for physicians, medical staff, and office staff on topics such as HIPAA compliance; medical-record documentation; physician-patient relationships; disclosure of untoward medical outcomes training; and preventing medication-related claims. (You may request a seminar for your group by calling the PSRM Department toll free at 800-227-4527.)
- **Informative articles** that discuss pertinent liability issues and include recommendations to prevent them.
- **Advice line** to help answer your professional liability questions. Call 800-227-4527, fax us at 510-420-7066, or e-mail us at patientsafetyriskmgmt@miec.com.
- **A website** that is a portal to valuable resources. Go to www.miec.com and visit:

1. **Who and Where We Insure** (Underwriting)
   - ✓ Calculate premium; get a group quote estimate; obtain information on cyber liability coverage
2. **Manage Your Risk** (Patient Safety & Risk Management)
   - ✓ Get free CME; visit the Patient Safety Toolkit
3. **How We Protect** (Claims)
   - ✓ Learn when to report a claim and whom to contact
   - ✓ Learn how to talk about disclosing an untoward outcome; call Claims

We welcome your inquiries and the opportunity to continue to serve you as we have for 40 years! Call us today!

CRICO Corner: General Medicine Analysis

CRICO Strategies — General Medicine Analysis in a Nutshell:

Report Years 2009–2013; 305 fully coded cases; $32 million total incurred losses

Key Findings:

General medicine (i.e., internal medicine and family medicine) was the primary responsible service in 47% of medicine specialty claims.

- Top three allegations for general medicine claims: diagnosis-related, medical treatment and medication management.
- Diagnosis-related claims account for almost 50% of general medicine claims.
- On par with peers, diagnosis-related cases result in high-severity injuries (79% for MIEC vs. 72% for peers); 57 deaths for MIEC.
- Clinical judgment, communication and patient-related behavior issues are the primary contributing factors that impacted the diagnosis-related claims.
- Cases are driven by challenges in the Diagnostic Process of Care in patient assessment/evaluation, diagnostic processing, provider follow-up and referral to specialists.

In 2015, MIEC and CRICO/RMF Strategies (the Risk Management Foundation for the Harvard system) conducted a comparative benchmarking analysis of MIEC's primary care medical events reported between 2009 and 2013. Of the 2,256 MIEC cases, 33% (655 cases) are medicine specialty cases. General medicine (i.e., internal medicine and family medicine) was named as the primary responsible service in 47% (305 cases) of the medicine specialty claims, with total incurred losses of $32,000,000. Other medicine (sub)specialties (i.e., cardiology, gastroenterology, dermatology, hospital medicine, pulmonology, and neurology) account for the primary responsible service in 53% of these medicine specialty cases, responsible for another $32,000,000 of total incurred losses.

Why do physicians struggle with diagnosis-related claims? CRICO Strategies offer this input echoed by MIEC's claims experience:

Diagnostic failures are "veiled": (1) Diagnosis of conditions occurs over long timespans making process failures hard to see — and report; (2) feedback is limited on errors; (3) there is limited data for analysis and linkage to organizational improvement.

Causes are multifactorial, and solutions are complex: (1) Well-known cognitive

drivers (bias) are challenging to address – and easier to see in others than ourselves; (2) involvement of multiple providers (physicians, radiology, lab results, etc.) increases the stakes in communication; (3) EHR systems perpetuate diagnostic processing challenges; (4) developments in medicine — imaging modalities, tests, and testing recommendations constantly change and impact how physicians diagnose medical conditions.

Focus of the analysis: Diagnosis-related claims for general medicine physicians

MIEC decided to take a deeper dive into our general medicine claims. We reviewed 135 cases with a report date between 2009 and 2013 with incurred losses of $17 million. As with other analyses MIEC has conducted with CRICO/RMF Strategies, the benefit of such an analysis is not only that it provides our policyholders with critical benchmarking data in the general medicine specialty, but the findings serve as a catalyst to further investigate, to dig deeper, and to uncover opportunities where MIEC can help policyholders mitigate risk, increase patient safety, and have a more robust understanding of what drives general medicine claims. Peer organizations included all Comparative Benchmark System (CBS) users and excluded academic medical centers.

Three primary medical negligence allegations were revealed through the general medicine analysis: diagnosis-related errors, mismanagement of medical treatment, and medication mismanagement. The diagnosis-related claims accounted for almost 50% of the general medicine claims, a number comparable to CRICO-benchmarked peers.

Location and severity of injury: As you would imagine, most of MIEC's general-medicine diagnosis-related cases occurred in an ambulatory setting (116 of the 135 cases), 112 of these in a hospital clinic/MD office, resulting in total incurred costs of $13,086,350 of the $15,423,718 spent on ambulatory-setting matters. One case arose out of an incident in a retail store, resulting in costs of approximately $70,000. As is found with peers, severity of injury is high (79% for MIEC vs. 72% for peers); 57 cases resulted in death.

Top two missed diagnoses: Cancer and heart disease

TOP FINAL DIAGNOSES	MIEC # CASES	MIEC % CASES	CBS % CASES
Cancer	57	42%	35%
Heart disease	30	22%	23%
Injury and poisoning	8	6%	9%
Diseases of the digestive system	5	4%	7%
Diseases of the musculoskeletal system and connective tissue	5	4%	3%
Diseases of the respiratory system	5	4%	4%
Infectious and parasitic diseases	5	4%	5%
Mental illness	4	3%	2%

Drilling down further in the cancer cases, we found that 10% of the cases were lung cancer, 7% colon cancer, 4% thyroid cancer, 3% breast cancer, and 2% prostate cancer.

Sample cancer cases: A 76-year-old patient had a chest X-ray which revealed a shadow in the left upper lobe; a CT was recommended; the primary care physician did not order a CT scan and advised the patient to return in three months. Unfortunately, the patient did not return. A pre-operative X-ray conducted at a later time revealed a diagnosis of lung cancer.

A 54-year-old patient was followed by a PCP; in the chart there was no documentation recommending screening colonoscopy. The PCP diagnosed anemia and labs were repeated; a colonoscopy was performed, and a malignant mass was discovered.

Top circulatory cases in the diagnosis-related matters

CIRCULATORY DISEASES	MIEC # CASES	MIEC % CASES	CBS % CASES
Cardiac arrest and ventricular fibrillation	5	4%	0.4%
Coronary atherosclerosis	5	4%	2%
Acute cerebrovascular disease	4	3%	4%
Peri-, endo-, and myocarditis; cardiomyopathy	3	2%	1%
Acute myocardial infarction	2	1%	5%
Congestive heart failure	2	1%	1%
Pulmonary heart disease	2	1%	3%

Sample cardiac cases: 56-year-old patient with a history of hypertension and diabetes; coughing up blood and pleuritic CP. Patient was told to go to ED but refused and came to office. PCP diagnosed pneumonia. The chest X-ray was not performed because the patient was too ill and went home. The patient was coded at home — acute MI. Of note: the patient had been referred to cardiologist and told to schedule a stress test. The patient failed to do so.

A 65-year-old patient complained of dizziness, heavy feeling on left side and difficulty holding cup. The PCP focused on the patient's dizziness due to antihypertension medication. Patient was advised to get up slowly; three days later the patient was diagnosed with ischemic CVA.

Contributory factors affecting, delay in diagnosis cases

The three most common contributory factors in the general-medicine diagnosis-related cases include: clinical judgment (90%), communication (39%), and patient behavior (33%), all comparable to CBS peers. Note: each case can have more than one contributory factor.

Clinical judgment factors:

- Failure to order diagnostic tests
- Narrow diagnostic focus; failure to establish a differential diagnosis
- Failure to obtain or delay in obtaining a consult or referral
- Inadequate patient assessment

Failure to rule out abnormal finding
Failure to respond to repeated patient complaints
Selection/management of medical treatment

Communication factors:

Between the provider and patient/family
Breakdown in communication between providers about patient's condition
Failure to provide patient education, follow-up instructions
Failure to read medical record (e.g., consultant report, PCP medical record)
Poor rapport with patient (unsympathetic response to patient)

Patient behaviors that impact diagnosis-related claims:

Noncompliance with recommended follow-up call/appointment
Noncompliance with prescribed treatment regimen
Seeking another provider when dissatisfied with care

Of the three primary clinical factors, CRICO Strategies coders found "failure to order diagnostic tests" and "narrow diagnostic focus" to be the most common (53 and 45 cases respectively).

Diagnostic process of care in the ambulatory setting

To better understand where the diagnosis-related errors occur, CRICO Strategies has broken down the diagnostic process to further home in on where it breaks down.

STEP	MIEC % CASES*	CBS % CASES*
1. Patient notes problem and seeks care	3%	1%
2. History and physical	8%	13%
3. Patient assessment/evaluation of symptoms	45%	34%
4. Diagnostic processing	48%	43%
5. Ordering of diagnostic/lab test	43%	45%
6. Performance of tests	4%	2%
7. Interpretation of tests	5%	8%
8. Receipt/transmittal of test results (to provider)	4%	4%
9. Physician follow-up with patient	35%	23%
11. Provider-to-provider communication	11%	13%
12. Patient compliance with follow-up plan	18%	20%

* CRICO's Comparative Benchmarking System (CBS) is an extensive database of medical malpractice cases (claims and suits) from academic and community hospitals and Physician Practice Groups within the Harvard system and across the country.

When examining MIEC data benchmarked against CRICO peers, patient assessment/evaluation of symptoms and diagnostic processing jump out as high when compared to the CBS community, as do physician follow-up with patients and referral management which mirror the identified contributory factors.

The evaluation found that 52% of MIEC's cancer cases had problems with patient

assessment/evaluation of symptoms vs. 40% of the peer group. Most striking was the diagnosis of lung cancer, where 15% of the MIEC cases had assessment issues vs. 7% of the CRICO Strategy peers. Although there were patient assessment issues in 13% of circulatory-system MIEC cases, this is a better experience than that of our peers, who experienced assessment issues in 23% of their diagnosis-related cases.

Physician follow-up with patients is also of concern in diagnosis-related cases, with 56% of MIEC cases vs. 61% of peer cases demonstrating failure to follow up with patients, and 15% vs. 13% in circulatory cases. The analysis also found that 7% of MIEC's mental health cases had issues with patient follow-up vs. 1% in similar peer cases.

Recommendations to help reduce diagnosis-related claims

MIEC and CRICO Strategies' analytical team offer the following recommendations to help our policyholders reduce their risk while enhancing patient safety:

Keep common diagnostic risks on your radar

- Review the IOM report *Improving Diagnosis in Health* on diagnostic errors procedures
- Review *Diagnosis* newsletter from the Society to Improve Diagnosis in Medicine — first online issue in 2014

Consider how you might improve patient assessment/evaluation

- Engage multidisciplinary team in strategies to improve team awareness, clinical communication, and accurate patient assessment
- Engage referring physicians and radiologists in processes to promote accurate assessment and communication of key findings

Improve systems and processes to lessen individual burden on memory

- Clinical decision support can help
- Team-based systems for loop closure can provide safety net

Analyze safety data

- Engage all team members in considering patient safety risks—has this type of event ever happened at our practice?

Educate providers on most frequently missed diagnoses

- Develop in conjunction with other disciplines
- Develop learning sessions with periodic competencies

Establish process for regular review

- Establish process for regular, ongoing peer review and audits to capture and understand errors and misreads

Access CRICO Safer Care Modules for self-assessment and improvement

- CRICO safe: https://www.rmf.harvard.edu/Clinician-Resources/Article/2014/Safer-Care-Library
- CRICO Breast Care Management Algorithm
- CRICO Colorectal Cancer Decision Support tool
- Communicate clearly with patients the clinical reasons for referrals and their urgency

Develop reliable processes to ensure follow-up

- Refer patients to specialists in a consistent manner

- Develop a follow-up system to consistently follow up on outstanding visits
- Ensure that specialists' reports are brought to the attention of the patient and providers

Capture and review events

- Diagnostic error reporting system
- Consider development of multidisciplinary Ambulatory M&M Rounds Diagnostic Root Cause Analysis (RCA)

Types and Origins of Diagnostic Errors in Primary Care Settings

Hardeep Singh, MD, MPH; Traber Davis Giardina, MA, MSW; Ashley N. D. Meyer, PhD; Samuel N. Forjuoh, MD, MPH, DrPH; Michael D. Reis, MD; Eric J. Thomas, MD, MPH

Importance: Diagnostic errors are an understudied aspect of ambulatory patient safety.

Objectives: To determine the types of diseases missed and the diagnostic processes involved in cases of confirmed diagnostic errors in primary care settings and to determine whether record reviews could shed light on potential contributory factors to inform future interventions.

Design: We reviewed medical records of diagnostic errors detected at two (2) sites through electronic health record–based triggers. Triggers were based on patterns of patients' unexpected return visits after an initial primary care index visit.

Setting: A large urban Veterans Affairs facility and a large integrated private health care system.

Participants: Our study focused on 190 unique instances of diagnostic errors detected in primary care visits between October 1, 2006, and September 30, 2007.

Main Outcome Measures: Through medical record reviews, we collected data on presenting symptoms at the index visit, types of diagnoses missed, process breakdowns, potential contributory factors, and potential for harm from errors.

Results: In 190 cases, a total of 68 unique diagnoses were missed. Most missed diagnoses were common conditions in primary care, with pneumonia (6.7%), decompensated congestive heart failure (5.7%), acute renal failure (5.3%), cancer (primary) (5.3%), and urinary tract infection or pyelonephritis (4.8%) being most common. Process breakdowns most frequently involved the patient-practitioner clinical encounter (78.9%) but were also related to referrals (19.5%), patient-related factors (16.3%), follow-up and tracking of diagnostic information (14.7%), and performance and interpretation of diagnostic tests (13.7%). A total of 43.7% of cases involved more than one of these processes. Patient-practitioner encounter breakdowns were primarily related to problems with history taking (56.3%), examination (47.4%), and/or ordering diagnostic tests for further workup (57.4%). Most errors were associated with potential for moderate to severe harm.

Conclusions and Relevance: Diagnostic errors identified in our study involved a large variety of common diseases and had significant potential for harm. Most errors were related to process breakdowns in the patient-practitioner clinical encounter. Preventive interventions should target common contributory factors across diagnoses, especially those that involve data gathering and synthesis in the patient-practitioner encounter.

JAMA Intern Med. *2013;173(6):418-425. Published online February 25, 2013. doi:10.1001/jamainternmed.2013.2777*

Improving patient care and patient outcomes using social media

According to Pew Research Center ("PRC") nearly two-thirds of American adults (65%) currently use social media networking sites, a significant increase from 2005 when they began tracking social media use. Social media has changed and continues to influence healthcare communication as Americans use social media to obtain information on physicians, diseases, disease management, treatment options, and diagnosis.[1] *Generally speaking, patients' desires to have quick access to health care information have not declined; instead they have become an expected component of communication. While technology has enhanced many*

1 Social Network Usage http://www.pewinternet.org/2015/10/08/social-networking-usage-2005-2015/

aspects of medicine such as medical record-keeping practices, sharing health information, and clinical communications between medical professionals, the use of social media in the physician-patient relationship can be problematic if used improperly. Taking into consideration PRC's data on increased use of social media in medicine, physicians can no longer discount its presence and impact in healthcare. Healthcare providers are encouraged to consider social media policies and procedures to safely incorporate this growing medium into their practices; however, they also must be cautious.[2] *With training and consistency, social media can be effectively used to improve the delivery of care, and have a positive effect on patient outcomes. This article explores the liability risks associated with social media and offers advice for safely incorporating social media into your medical practice.*

2 Social Network Usage http://www.adweek.com/socialtimes/heres-how-many-people-are-on-facebook-instagram-twitter-other-big-social-networks/637205

Using social media to improve patient satisfaction, patient safety, and patient outcomes

The growing use of social media provides an excellent opportunity to improve the physician-patient relationship by providing services and information that until now have been unavailable. Social networking platforms such as Facebook®, Twitter®, and YouTube®, professional blogs, and practice websites are effective tools to educate and update patients on a variety of non-clinical issues such as changes in office hours, educational workshops, staff changes, and highlighting the accomplishments and accolades of your medical practice. Digital access to clinical concerns regarding vaccine availability, medication and equipment recalls, and even disease management may also increase patient satisfaction by providing another mechanism to access information. When used skillfully by physicians, social media provides patients the latest information on regular exercise, balanced nutrition, smoking cessation, and other healthy choices and lifestyles that improve patient safety and outcomes.

Although patients are increasingly turning to the Internet for reliable information on medical conditions, diseases, and diagnoses, a recent article in *Medical Economics* cautions physicians that Wikipedia has inaccurate information on top medical ailments searches.[3] Therefore, in order to correct misinformation found online, physicians should use patients' concerns and questions from Internet research as a perfect opportunity to improve patient education by discussing questions and referring them to reliable and trusted sources for medical information.

Using social media to enhance physician communication

Professional social media sites provide networking communities that enhance the sharing of information in an environment where like-minded physicians gather. Physicians are realizing the benefits of using social media as an instantaneous method to confer with professional colleagues on changes to the standard of care, discuss medical studies, obtain CME credits, share information on the latest medical procedures, and introduce new medical equipment. An earlier PRC study

3 Incorrect Wikipedia ailments http://medicaleconomics.modernmedicine.com/medical-economics/content/modernmedicine/modern-medicine-feature-articles/wikipedia-has-wrong-inform

of physicians revealed that 90% of physicians use at least one social networking site for personal use, but 65% use social media for professional purposes. By contrast, medical students graduating in 2018 have reported that: 86% have an active account at Facebook, Twitter, or LinkedIn; 96% upload images to Flickr or Facebook; 78% upload videos to YouTube; 65% contribute to a wiki or a blog; and 97% use Skype or FaceTime for video or voice communications.

Regulating social media

Presently there are no universal laws or governing bodies to regulate social media content; however, the role at the Federal Communication Commission (FCC) as the country's primary authority for communications laws, regulations, and technological innovations is now expanded to include Internet activity. In spite of its rapid growth, social media remains largely unregulated; there are no requirements to (1) ensure the accuracy of information posted about you by patients; (2) reveal an author's identity; or (3) provide links to dependable resources. Because patients are turning to social media for answers to medical questions that historically have been reserved for a face-to-face physician-patient encounter, the American Medical Association along with other professional associations and colleges has developed social media policies for interaction outside of the traditional office setting.[4] Likewise, many healthcare institutions have adopted social media policies to govern physicians' online behaviors that may compromise patient confidentiality or otherwise breach ethical obligations.

Privacy and confidentiality using social media

A physician's duty to maintain patients' confidentiality includes use of social media. For all its benefits, the use of social media in medicine may contribute to inappropriate disclosure of protected health information (PHI). Lawsuits against health care providers who improperly disclose patient information are growing at an alarming rate, and allegations of a breach of confidentiality are becoming more frequent as social media permeates our society. Social media privacy violations involve not only the HIPAA Privacy Rule that ensures PHI is kept safe, secure, accessible, and available for those who have the authorization and a valid need to access it, but also the Security Rule that requires administrative, physical, and technical safeguards be implemented to protect electronic protected health information (ePHI). HIPAA lists 18 personal identifiers *(Section 164.514(a) of the HIPAA Privacy Rule*[5]*),* including full-face photos (or comparative images), medical record numbers, birth dates, and more; release of information containing these identifiers constitutes a breach. In 2011, a Rhode Island emergency department physician was fired, lost her hospital privileges, was reprimanded by the state medical board, fined $500.00, and had to take a continuing education course for posting information online about a patient. Although the patient's name had been omitted, the post included enough patient-specific information about the injury that the patient's identity was revealed. De-identifying patient information can be difficult as it involves more than just a patient's name. To reduce the possibility of a HIPAA violation, physicians should

5 tips for online behaviors that reduce liability exposure

1. Maintain separate private and professional profiles.
2. Maintain professionalism. Do not confirm a physician/patient relationship without prior patient authorization.
3. Do not respond to online reviews without speaking with MIEC to discuss an appropriate response.
4. Resist providing patient-specific medical advice to patients without an established relationship to your practice.
5. Have a designated staff member or website designer maintain your digital footprint so that information posted is timely and accurate.

4 AMA Guidelines / Policy (http://journalofethics.ama-assn.org/2015/05/nlit1-1505.html)

5 HIPAA De-identification Markers http://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/

FIVE STEPS TO CONTROL YOUR DIGITAL FOOTPRINT

1. Google (or BING) yourself! See what your patients see when they search your name.
2. Search the Internet for "website analysis" tools to assess the effectiveness of your website.
3. Take advantage of Search Engine Optimization (SEO) tools to improve your ranking placement in search results.
4. Manage and update your professional online profile content (e.g., Healthgrades [https://www.healthgrades.com/] , Zocdoc [www.zocdoc.com], Rate Mds [www.ratemds.com]). These sites will obtain information about you from various locations and will create your profile without your input or verification of the information.
5. Use a professional digital reputation management company to monitor what is said about you and your practice online.

ensure that everyone in the practice is familiar with HIPAA regulations and has completed compliance training. It is also suggested that HIPAA updates and refresher courses be offered annually.

Responding to online reviews

Negative online reviews of physicians, their staff and their practices are becoming more common as patients discover the power of an online review. Information about you found on review sites frequently influence a patient's decision to seek care from you. Before scheduling an appointment, patients now head to sites like: www.Healthgrades.com, www.AngiesList.com, www.Vitals.com, and www.Zocdoc.com for information not only on physicians' demographics, certifications, credentials, and medical board actions, but also on the ease of scheduling, wait times, bedside manners, and customers' experience with office staff. One of the most common forms of feedback is whether a patient would recommend you to a friend or relative. Many physicians have been the target of unsubstantiated allegations of improper care or poor communications from unhappy patients turning to the Internet for retaliation. Physicians' automatic impulses to respond and attempt to correct a negative online review are understandable; however, the Office of Civil Rights has opined that absent prior patient authorization, **physicians may not confirm the existence of a physician-patient relationship when responding to an online review**. Even when online communication is initiated by the patient, physicians are cautioned not to respond in a manner that breaches PHI and/or confirms the existence of a physician-patient relationship. MIEC suggests the following options to appropriately respond to negative online reviews and improve your digital reputation without breaching patient confidentiality:

- Update your patient information form to include authorization to respond to online reviews. A simple question such as "Do we have your permission to respond to online comments you make about Dr. XX, his/her staff and/or practice?" reduces the possibility that your response may be seen as a HIPAA violation.
- Call the patient and discuss their concern. In order to determine what caused the patient to write a negative review about you, set aside time to have a discussion in a private location without distractions.
- Invite patients to write an online review of their positive experience with your practice. The more positive reviews you have, the less likely that negative reviews will appear at the top of the search results... for your name or practice.

Call MIEC's Patient Safety & Risk Management team for general guidance and the Claims Department for patient-specific advice on responding to online reviews.

Protecting yourself from the liability risks of using social media

First, educate yourself, your staff, and your patients on the risks and benefits of using social media to enhance the physician-patient relationship, reduce patient injury, and improve patient satisfaction. Next, consider the following recommendations for incorporating social media into your medical practice:

✓ Develop protective policies that are designed to reduce your risks and liability.

- ✓ Create written social media policies and agreements for your staff and patients to adhere to. Sample social media policies are quickly found by a Google search.
- ✓ Avoid the urge to respond to negative reviews. MIEC policyholders should call the Claims Department for assistance.
- ✓ Know what to do when there's a security or policy breach in your use of social media.
- ✓ Do not post anything online that you wouldn't write in a paper chart. Remember that no internet posting, including those on social media platforms, can be permanently deleted. The emerging field of digital forensics allows experts to obtain previously deleted content regardless of a user's privacy settings.

The genie is out of the bottle, and no matter how hard you try, it's not going back in. Take appropriate steps to reduce your risk of liability and leverage the benefits of social media. Physicians are best protected when they use social media as an additional resource to improve patient safety, patient education, and patient compliance to medical advice. Contact MIEC's Patient Safety & Risk Management Department for additional social media resources and sample templates.

8 Ways to Effectively Use Social Media to Enhance the Physician-Patient Relationship

1. Build your library. Posting links to news articles, journal articles, and online resources is an extremely easy way to keep track of content that interests you and can be shared with others. It is hard to keep up with all of the research and healthcare news without having to visit each individual source on a regular basis. Fortunately, most major journals and news sources are on social media, and with a simple click of the "follow" button, you can stay in the loop with much less effort.
2. Find collaborators. Science is a team sport, so don't be limited to just professional colleagues you already know. Connect with other professionals ro share knowledge and best practices.
3. Promote health literacy. Patients look to the Internet to find answers to their medical questions. In the absence of physician-created content — such as blog posts, open access papers, slideshows-what will they find? Leverage social media to provide patients with reliable information.
4. Engage in professional advocacy. Healthcare delivery is a business. Social media is a great means to advertise your skills, services, hours of operations, etc., in a way that distinguishes you from other physicians.
5. Grow your practice by helping patients find you. Make it easy for people to find YOU when they search for an expert in your specialty. When someone searches "best [your specialty] in [your area]," does your name or your practice group appear at the top? If not, control your digital footprint; positive presence on the Internet can go a long way towards influencing the way Google ranks you. (See sidebar on page 10 for suggestions on controlling your digital footprint.)
6. Manage your professional reputation and what patients see about you. Most physicians are listed on literally hundreds of physician rating websites; many of those physician profiles are blank, sparsely populated, or contain errors. Negative reviews are very damaging even if they are unfounded. A little bit of active web presence can outrank those meaningless or harmful links.
7. Know what your patients are reading. Not everything on the internet is accurate, so find out what your patients are learning so you'll be prepared to discuss the content with them.
8. Maintain separate social media profiles. Maintain a personal profile reserved for family and friends. Create a practice website or social media page that invites patient participation. Help more patients than just those in your daily practice by being involved in policy, whether local, regional, or national.

Medical Marijuana Update

Come senators, congressmen
Please heed the call
Don't stand in the doorway
Don't block up the hall…
For the times they are a-changin

Although Bob Dylan's classic protest song speaks to a host of political issues, one could argue that the lyrics are prophetic with respect to the current movements for and against the legalization of marijuana for medicinal and recreational use. In light of recent statutory changes, we at MIEC are providing this update on medical marijuana laws at the federal and state level.

Federal Law

While your state's laws may allow you to recommend marijuana for medicinal purposes, federal law does not. Federal law considers marijuana a Schedule I drug and continues to prohibit obtaining, possessing, cultivating, and using cannabis, marijuana/hashish, etc., including for purposes of medical treatment. Physicians are NOT immune from possible arrest if they obtain, possess, cultivate, or aid and abet a patient in doing the same. Federal law establishes a clear prohibition against knowingly or intentionally distributing, dispensing, or possessing marijuana.[6]

The Conflict Between Federal and State Marijuana Laws

Possession or cultivation of any amount of marijuana is a federal crime, subjecting a defendant to fines, prison time, or both. Large scale cultivation and trafficking (transporting or selling marijuana, often across state lines) incurs harsher penalties, and this tends to be the main focus of federal drug enforcement attention.

Despite this wholesale federal ban, **since the mid-1990s 23 states and the District of Columbia have enacted laws that allow or protect the medicinal use of marijuana.**[7] Most of these states have decriminalized medicinal marijuana use for patients who follow the law with respect to amounts, registration, and so on. State-level penalties still apply to those who break state laws.

Obviously, there is a conflict between federal classification under the Controlled Substances Act, which criminalizes all marijuana-related activities, and state medical marijuana laws, which recognize and protect medicinal marijuana cultivation, possession, and usage. But despite the continued viability of the federal approach, individual medicinal marijuana patients are relatively unlikely to face penalties from the federal government.

State Law

ALASKA

Sec. 17.37.010. Registry of Patients [8]

(a) The department shall create and maintain a confidential registry of patients who have applied for and are entitled to receive a registry identification card according to the criteria set forth in this chapter. Authorized employees of state

6 Health & Safety Code §11362.5

7 http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx

8 http://medicalmarijuana.procon.org/sourcefiles/alaska-ballot-measure-8.pdf

or local law enforcement agencies shall be granted access to the information contained within the department's confidential registry only for the purpose of verifying that an individual who has presented a registry identification card to a state or local law enforcement official is lawfully in possession of such card.

(b) No person shall be permitted to gain access to names of patients, physicians, primary caregivers or any information related to such persons maintained in connection with the department's confidential registry, except for authorized employees of the department in the course of their official duties and authorized employees of state or local law enforcement agencies who have stopped or arrested a person who claims to be engaged in the medical use of marijuana and in the possession of a registry identification card or its functional equivalent.

(c) In order to be placed on the state's confidential registry for the medical uses of marijuana, a patient shall provide to the department:

(1) the original or a copy of written documentation stating that the patient has been diagnosed with a debilitating medical condition and the physician's conclusion that the patient might benefit from the medical use of marijuana; **"debilitating medical condition"**[9] means: cancer, glaucoma, positive status for human immunodeficiency virus, or acquired immune deficiency syndrome, or treatment for any of these conditions; any chronic or debilitating disease or treatment for such diseases, which produces, for a specific patient, one or more of the following, and for which, in the professional opinion of the patient's physician, such condition or conditions reasonably may be alleviated by the medical use of the marijuana: cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; or persistent muscle spasms, including those that are characteristic of multiple sclerosis.

9 http://dhss.alaska.gov/dph/VitalStats/Documents/PDFs/MedicalMarijuana.pdf

Ballot Measure 2[10]

In November 2014, Alaska voters adopted an initiative legalizing personal, nonmedical use of marijuana in the state. Ballot Measure 2 expands the legalized possession of marijuana for personal use by adults and sets up a system to license, regulate, and tax commercial production, processing, and sales of the drug for personal use.

The Alaska law legalizes the possession of marijuana by adults age 21 and older for personal, nonmedical use. Ballot Measure 2 expressly states that it will not "diminish the rights" of medical marijuana patients under Alaska's existing medical marijuana law.

CALIFORNIA

On November 5, 1996, voters passed Proposition 215, "The Compassionate Use Act of 1996,"[11] which gave physicians in California the right to discuss, advise, and possibly recommend the use of cannabis for serious medical conditions, in accordance with the standard of the physician's office practices. Arising out of the Conant v. McCaffrey case is a list of those conditions:

- severe nausea (commonly associated with HIV/AIDS and cancer);
- wasting syndrome or anorexia (commonly associated with HIV/AIDS);
- increased intraocular pressure (commonly associated with glaucoma);
- seizures or muscle spasms associated

10 https://ballotpedia.org/Alaska_Marijuana_Legalization,_Ballot_Measure_2_(2014)
11 https://ballotpedia.org/California_Proposition_215,_the_Medical_Marijuana_Initiative_(1996)

with a chronic, debilitating condition (commonly associated with epilepsy, multiple sclerosis, and paraplegia/quadriplegia/hemiplegia);

- severe chronic pain (commonly associated with paraplegia/quadriplegia/hemiplegia, HIV/AIDS, metastasized cancers, and cervical disk disease).

Importantly, if a physician is willing to discuss, advise or recommend cannabis use, he or she must do the following:

- Conduct a good-faith exam;
- Ensure that the patient has a serious medical condition;
- Document the results of the examination, history, discussion and the physician's basis for the conclusions drawn;
- Consult with or obtain the patient's medical history or medical records, to determine diagnoses, and previous care and treatment from the previous treating physician;
- Refer to a specialist when appropriate to do so;
- Follow the patient at appropriate intervals to ensure safety and the effectiveness of the marijuana use;
- Inform the patient of the potential risks and benefits of cannabis use, and alternatives to its use; and,
- Inform the patient that federal statutes are still in effect and that California law would not necessarily immunize the patient from prosecution for cannabis use.

If California physicians write any recommedation for patients in regard to the use of cannabis, they should do so with the knowledge that under federal law the penalty for writing a recommendation is up to five years' imprisonment, a fine of $250,000, or both, and possible other federal sanctions, such as the loss of their DEA registration. A felony conviction would result in mandatory exclusion from Medicare and Medi-Cal. The California Medical Association opines that if a physician's recommendation for cannabis use is proven to be specifically to help a patient obtain the drug, even from a marijuana club, the recommendation would not be protected by California law or the First Amendment.

California Medical Marijuana Program

The California Department of Public Health's Medical Marijuana Program (MMP) was specifically established to create a state-authorized medical marijuana identification card (MMIC), along with a registry database for verification of qualified patients and their primary caregivers. Participation by patients and primary caregivers in this identification card program is voluntary. The MMP web-based registry allows law enforcement and the public to verify the validity of a qualified patient or primary caregiver's MMIC as authorization to possess, grow, transport, and/or use medical marijuana within California.[12]

Physicians should be aware of the following: The California Medical board is tasked with prioritizing the investigations of physicians who excessively recommend cannabis for medical use, fail to have a bona-fide patient relationship with those persons for whom they recommend cannabis, or fail to adhere to sufficient record-keeping regarding their cannabis recommendations. For more information, visit the Medical Board of California website.[13]

12 https://www.cdph.ca.gov/programs/MMP/Pages/default.aspx
13 http://mbc.ca.gov/Licensees/Prescribing/Medical_Marijuana.aspx

HAWAII

On June 14, 2000, Governor Ben Cayetano signed Senate Bill 862,[14] which established the Hawaii Medical Marijuana Act to remove state-level criminal penalties on the use, possession, and cultivation of medical marijuana by patients who possess a written certification/medical marijuana recommendation from their physician or their advanced practice registered nurse. Qualifying patients must register with the Narcotics Enforcement Division (NED). Patients or their caregivers may possess up to three ounces of usable marijuana, and may cultivate up to seven marijuana plants, three of which may be mature.

Currently qualifying conditions and diseases set by the Legislature are restricted to:

- Malignant cancer
- HIV/AIDS
- Glaucoma
- Profound wasting disorders
- Chronic nausea
- Chronic disabling severe pain of all sites
- Chronic disabling muscle spasms (and similar spastic disorders, such as asthma under certain conditions)
- Seizure disorders
- Inflammatory bowel disorders
- Multiple sclerosis
- Chronic headache
- Painful neuropathies and fibromyalgia
- Migraines
- War/combat and service-related injuries, illnesses, and traumas do qualify
- PTSD has been recently approved by the Department of Health to qualify patients for a cannabis license, to accommodate military veterans with service-related injuries, and combat-related conditions

Patient Possession Limits

Four ounces of usable marijuana at any given time, jointly possessed between the qualifying patient and the primary caregiver. "Usable marijuana" does not include the seeds, stalks, and roots of the plant.

Home Cultivation

No more than seven marijuana plants, whether immature or mature.

Effective July 18, 2015,[15] Hawaii's Medical Use of Marijuana Program was transferred from the Department of Public Safety to the Department of Health (DOH).

Caregivers

A primary caregiver is a person who has the responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana. Primary caregiver is a person other than the qualifying patient, or the patient's physician. The caregiver must be 18 years of age or older. Qualifying patients shall have only one primary caregiver of any given time. Primary caregiver shall be responsible for the care of only one qualifying patient at any given time.

IDAHO

The year 2015 marked a chance for Idaho to move toward a compassionate marijuana policy. The Idaho Legislature approved Senate Bill (SB) 1146[1] and sent it to Governor Butch Otter. The bill would have allowed physicians to recommend certain medical cannabis oils to patients with one of several conditions. However, Governor Otter vetoed the bill, and marijuana possession, sale, and distribution

14 Haw. Rev. Stat. §§ 329-121 to 329-128 (2008)
Haw. Rev. Stat. §§329-121; 329-123 (b),(c) (2008)

15 http://health.hawaii.gov/medicalmarijuana/file/2015-FINAL_Approved-Rules-effective-7-18-15.stamped.pdf

continue to be highly regulated by both state and federal law. In Idaho, marijuana is regulated as a Schedule I controlled substance, categorizing it as a drug with a high potential for abuse and no recognized medical use.

Subsequent to vetoing SB 1146, Governor Otter issued executive order 2015-03, allowing the state to implement an "Expanded Access Program," an FDA-approved program allowing access to a purified form of cannabidiol (CBD) oil called Epidiolex manufactured by GW Pharmaceuticals. The program is limited to 25 children (ages 0–18) with intractable epilepsy who have not responded to standard medications.

Finally, we know that the delivery of healthcare is in a dynamic state, and that change is our constant companion. Hence, with respect to the current movements for and against the legalization of marijuana for medicinal and recreational use, one can expect that these issues, too, will continue to evolve over time.

Claims Corner – Q&A: Maintaining Accreditation Standards and Risk; Health Fairs

My facility is accredited by my specialty society for various medical or diagnostic services. How is my liability affected if I fail to maintain that accreditation?

Facilities that use diagnostic equipment and radiologic machines such as breast MRI, CT, MRI, nuclear medicine, and PET scans must maintain the appropriate credentials and certifications in order to provide quality patient care and to decrease the chance of liability.

According to federal law, as mandated under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), as well as for modalities mandated under the Mammography Quality Standards Act (MQSA) of 1992 (as amended in 1998 and 2004),[16] facilities must meet specific requirements to perform services. MIPPA requires that all providers of CT, MRI, breast MRI, nuclear medicine, and PET exams who bill under Part B of the Medicare Physician Fee Schedule must be accredited in order to receive payment for the technical component of these services. The CMS/MIPPA mandates apply to private outpatient facilities only. The CMS accreditation requirements apply to the quality of imaging, equipment performance, safety standards for staff and patients, as well as quality assurance and control.

Please note: States may differ in their laws regarding diagnostic credentials and certifications. You should familiarize yourself with the laws in your state.

Example – Mammography

Under federal law, if your facility is found to be in violation of the requirement to maintain appropriate credentials for your diagnostic services, your facility may be investigated by the FDA's Division of Mammography Quality Standards (DMQS), an FDA-approved state certifying agency, or your facility's accrediting body such as the American College of Radiology (ACR).

If there are concerns with the quality of your facility's clinical images or if your diagnostic equipment accreditation has lapsed, the DMQS may begin a process called an Additional Mammography Review (AMR). According to the FDA, an AMR is "an evaluation of the clinical image quality of a sample of mammograms performed at the facility."[17] If the AMR finds that the mammography device is performing below the standard (based on MQSA standards) and presents a risk to patients, the FDA may then require the facility to go through the process of a PPN (Patient and Provider Notification). The PPN process includes the following steps:

16 http://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/ucm110849.pdf
17 http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/FacilityScorecard/ucm512966.htm

- Identify the at-risk patients and their referring healthcare providers. At-risk patients include those who had mammograms at the facility during the timeframe defined in the PPN letter. The facility must submit the names of the at-risk patients, along with the names of their referring healthcare providers, to the compliance officer within two weeks of receiving the PPN letter.
- The PPN letter includes patient and provider notification letter templates. The facility must use the notification letter templates to inform patients and providers of the serious concerns regarding the quality of mammography at the facility. The letters are also designed to guide patients and providers as to what actions they should consider taking in response to the notification.
- Once the notification letter templates have been approved by FDA, the facility must mail, via a trackable mailing system, the provider letters within 5 days of approval and the patient letters within 5 to 7 days after the provider letters have been mailed.
- Each week after the facility has begun mailing the provider notification letters, the facility must submit copies of delivery confirmation to the compliance officer. Once all patients and providers have been notified, the compliance officer conducts a random audit of the PPN.
- Once the compliance officer determines that the PPN was effectively executed, the compliance officer issues a PPN closeout letter to the facility documenting that it successfully completed the PPN.[18]

According to the FDA, successful completion of the PPN is required prior to the facility having its accreditation reinstated and receiving an active MQSA certificate. The FDA is also required by Congress to actively and publicly report on their website ongoing investigations, adverse events, and corrective actions involving the facilities under review.

In addition to the federal requirements of compliance with an AMR, PPN, and accreditation reinstatement, facilities may still be held liable for delays in and/or failures to diagnosis pathologies in their patient populations. Claims can arise from patients who have experienced or allege to have experienced delays in treatment due to malfunctioning or sub-standard diagnostic equipment. Therefore, it is of utmost importance to remain compliant with your state and federal regulations with regard to diagnostic and radiologic equipment accreditations. Please remember that technicians or clinicians who use the devices for diagnostic services also must be in compliance with state and federal licensing and credentialing requirements.

If you discover that your imaging center is out of compliance with state or federal regulations, or a complaint is filed against your facility, immediately contact MIEC's Claims Department at 800-227-4527. Policyholders in Alaska, call our Claims office in Anchorage at 907-868-2500; Hawaii policyholders, call our Claims office in Honolulu at 808-545-7231; and Idaho policyholders, contact our Claims office in Boise at 208-344-6378.

I have been asked by a local organization to participate in a health fair. I'm not really sure what I can and can't do to ensure I don't expose myself to liability. For example: What do I do if my cursory review uncovers a significant finding? Am I really giving medical advice at a health fair? Do I need to document the advice? Do I need to obtain informed consent?

Physicians and healthcare providers are often asked to engage in the provision of healthcare services and screenings in the community. In a 2010 article by the organization Unite for Sight, the author calls into question the value of such fairs, citing as a primary resource a 1985 article by former administraor of the Centers for Medicare and Medicaid Services Donald Berwick, MD.

Quoting the article,

> *"Health fairs are one of the most recognizable forms of community-based health promotion conducted in the United States. Health fairs are voluntary programs, which typically last a few days, and offer health education and medical screenings at little or no cost. Most fairs measure height, weight, blood pressure, vision, and anemia, while other popular tests include blood chemistry, oral screenings, podiatry exams, hearing tests, and glaucoma screenings. Though these fairs in theory may seem like a good idea, the medical literature has often viewed them with considerable skepticism. 'Health fairs are neither regulated nor routinely certified in the United States,*

18 *ibid*

and complete data on their numbers and content are not available.' (1) In addition, the laboratory screening tests offered at many health fairs may cause more harm than good. These tests may unnecessarily alarm participants with erroneous abnormal results, or provide a false sense of reassurance if results are shown to be normal. Despite these concerns, health fairs continue to attract large numbers of people." [19]

Should you be invited to participate in a community health fair, we recommend that you ensure the following:

(1) Find out from the event organizer whether the **fair must be registered with your state's Medical Board**. For example, California's Business and Profession's Code, Section 901, has registration and record-keeping requirements for sponsored free healthcare events, including registering physicians who participate in the event.

(2) Determine whether the sponsoring organization provides **event-specific liability coverage**.

(3) Notify MIEC that you **plan to provide specialty-specific services for a community health fair**. Contact the Underwriting Department.

(4) Prior to conducting any screening tests or giving limited medical advice, **participate in a brief informed-consent discussion** that includes a statement such as, "this informal consultation does not substitute for a complete clinical examination and evaluation. Tests are screening only and are not designed to diagnose a significant condition or medical problem. If you have a medical concern, make an appointment with your primary care physician." Reinforce the conversation by having the patient sign a consent form. Sample forms frequently include disclaimer language that reiterates the screening nature of health fair evaluations.

(5) Acknowledging the limited nature of the information you obtain in the Health Fair setting, **limit also the advice you give**. Advise patient of normal findings, and document the conversation. If you discover a significant abnormal finding, advise patients to seek further medical attention either from their primary care physician, from a specialist, or from a local clinic, if the patient is uninsured. Clearly state why the patient needs to follow up.

(6) Consider the wisdom of conducting **lab tests at a health fair**. Some concerns raised by experts include the "arbitrary threshold values used to determine if someone is 'normal' or 'diseased,'" and lulling patients into a false sense of security with a test result that be deemed "normal" because the threshold value is much higher than values physicians would normally treat in their practices.[20]

(7) Retain health fair documentation for **the minimum amount of time required by state or federal law**. See MIEC's newsletter, "How long do we have to keep medical records?" (http://www.miec.com/Portals/0/ManagingYourPractice/MYP1B.pdf).

(8) Ensure that the sponsor of the health fair has an emergency response plan in place (e.g., access to 911, ambulance service, etc.).

19 "Challenges and Failures of Health Fairs and Community Screenings," Unite for Sight, October 2010, http://www.uniteforsight.org/health-screenings/health-screenings
20 *Ibid*

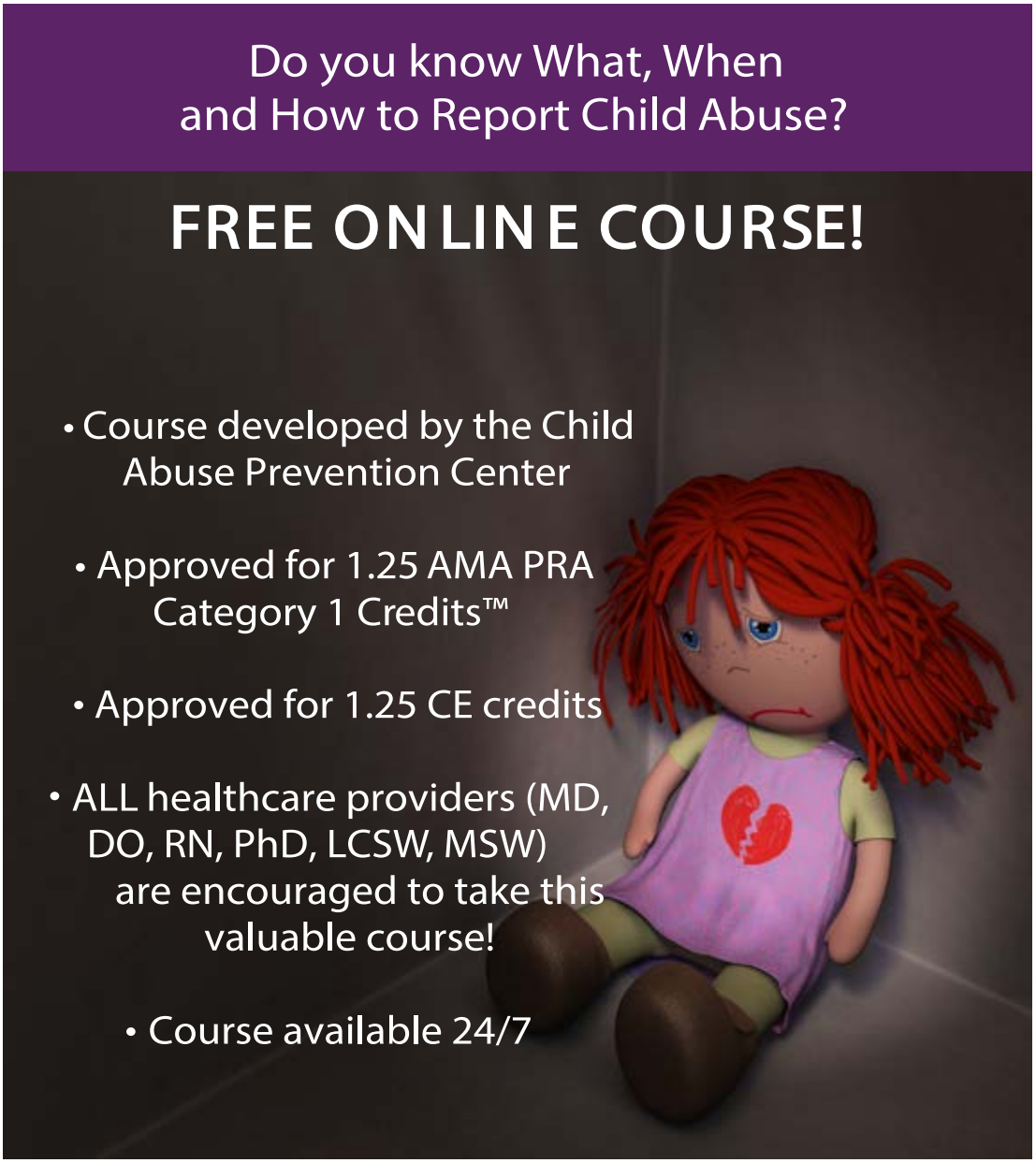
For more information, contact MIEC's Claims or Patient Safety and Risk Management Department.

Free Online Course on Child Abuse Prevention, Recognition, and Reporting

The Institute for Medical Quality (IMQ) is pleased to offer an excellent course on Child Abuse Prevention, Recognition, and Reporting. This 75-minute course, created by the Child Abuse Prevention Center in Sacramento, is designed for physicians, nurses, and other healthcare professionals who are mandated by law to report suspected child abuse and neglect, but who may not be thoroughly familiar with the signs and symptoms or may not know have, when or to whom to properly report findings. Upon completion of the course, learners will receive continuing education credits commensurate with their degree.

The course is offered free of charge, through a grant to IMQ from the California Governor's Office of Emergency Services (Cal OES), and is available exclusively to licensed California physicians, nurses and other healthcare professionals. Under the terms of the grant, preregistration is required that includes name, degree (e.g., MD, DO, RN, PhD, LCSW, MSW), License Number and email address. After you submit this information, an email is sent with the link to the full registration and access to the course.

If you have questions about the course, please contact Leslie Anne Iacopi, MBA, Manager, Medical Staff and Professionalism Program at liacopi@imq.org.



FREE CME courses from MIEC

ELM Exchange, Inc.

MIEC has partnered with ELM Exchange, Inc., to offer risk management continuing education courses. All or a portion of your annual risk management course requirements may be satisfied through the ELM online program. Risk management training is a means of reducing adverse events, mitigating professional liability, and improving patient safety at an individual and system level.

To find out more about current CMEs from ELM Exchange, go to www.miec.com > Manage Your Risk > CME Courses

Empathetics

MIEC is excited to offer policyholders access to evidence-based training designed to help physicians understand and appreciate the many components of empathy and its effect on the physician-patient relationship. Visit www.miec.com for more information on how to register for these CME-eligible courses. **Look for the CME Courses tab under the Manage your Risk information.**

How to reach MIEC

PHONE:

Oakland Office: 510/428-9411
Honolulu Office: 808/545-7231
Boise Office: 208/344-6378
Alaska Office: 907/868-2500
Outside: 800/227-4527

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