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Copiscope

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Please save all issues of Copiscope for future reference

COPIC INSURANCE

All Physicians

Practice Quality, L.L.C. to Provide Valuable Risk Management Assessments

After considerable input from Practice Quality, L.L.C., COPIC's Risk Management department, and our insured physicians, we will be instituting a new program that will help our insureds avoid malpractice claims as well as protect their premiums.

Starting with current office reviews and becoming fully effective January 2002, COPIC's Practice Quality business unit will conduct risk management assessments of every office practice visited. Insureds practicing in offices that meet the risk management guidelines will receive one ERS point for each cycle in which the guidelines are met.

The newly developed risk management guidelines are based on claims and incident experience demonstrating certain high risk functions associated with increased claims, increased claims severity, and reduced defensibility of claims when they occur. The assessment's focus is to help our insured physicians learn of these high-risk areas and develop ways to improve the functions of their office personnel and systems to deal effectively within them.

Offices that do not meet the guidelines will be given assistance and a six-month period before a second review to determine if the guidelines have been met. Once practices meet the guidelines, these insureds will also receive one ERS point. If insureds choose **not** to meet the guidelines following the six-month period of assistance and review, a negative ERS point will be assessed for each cycle. This negative can be converted to a positive ERS point once the risk management guidelines are met.

The risk management guidelines are divided into Level One and Level Two guidelines. To obtain one ERS point, offices must meet 100% of the Level One guidelines. Level Two guidelines are for informational purposes for the offices and do not count towards the ERS program noted above. The entire risk management guidelines, which include the Level One guidelines in more detail as well as the informational Level Two guidelines, will be available January 1, 2002 by calling (720) 858-6126 or (800) 421-1834 ext. 6126.

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Practice Quality (from page 1)

A short summary of the Level One guidelines follows:

LEVEL ONE GUIDELINES (Practices must meet 100% of these guidelines for the 2002-2003 ERS cycle to earn 1 ERS point)

PRESCRIPTION MEDICATION LIST

This is important to help avoid drug-drug interactions, determine dosages and frequencies of medications prescribed, and provide information regarding refills. For primary care physicians, medical specialists or other specialists functioning as primary care physicians, it is highly recommended that a "formal" medication list be present and maintained in the patient charts. It should identify all of the patient's acute and chronic medications and appear in a prominent or easily found location (preferably in the front of the medical record). Alternatively, for any physician, a complete list of the patient's medications, dosages, and frequencies can be assessed and documented at each patient encounter. This then becomes a "functional" medication list in that anyone needing updated information can turn to the most recent visit to obtain it.

Procedural specialists with episodic, problem-focused responsibilities may substitute a history "intake form" for the medication list. It must appear in a prominent or easily found location in the medical record (preferably in the forefront of the chart). It should be updated on a regular basis, preferably at each patient encounter, but at least at any encounter where a new medication is prescribed that could potentially interact with a patient's current medications.

To Meet Level One Guidelines

- Current and complete medication list in a prominent or easily found location or
- Medications assessed at each visit or
- For procedural specialists with episodic, problem-focused responsibilities: an intake form that includes a complete and current list of the patient's medications

ALLERGY FLAGS

Allergies and adverse reactions or no known allergies (NKA) should be documented clearly on the outside of the medical record or on the problem list located at the front of the chart. Documentation of allergies at each visit in places other than in one of these locations does not meet this guideline.

To Meet Level One Guidelines

- Allergies and adverse reactions or NKA documented in a designated location

TELEPHONE CHARTING

All telephone communication, either during or after office hours, should be documented in the medical record when one of the following occurs:

- Prescribing or changing medication
- Making a diagnosis
- Directing treatment
- Directing patient to another provider or facility

It is important to include the date and time of the phone conversation. A telephone message slip with the documented advice and decisions reached should be attached securely to the medical record.

Patient's recollections of phone calls, what was discussed during the phone call, and whether the calls were returned are frequently important elements in how a claim proceeds. A simple log of all incoming phone calls kept in a chronological fashion may help to resolve this potential source of conflict. Should a patient then indicate that a phone call was made on a particular day, the call can be confirmed by referring to the log. Since after-hour calls often deal with what are perceived by patients as acute problems, they may lead to litigation if they result in poor outcomes or hospitalization. That is why recording all phone calls is extremely important in managing risk. It may be difficult to record all after hour phone calls; therefore COPIC has developed a Patient Phone Call Record Book to help physicians document these calls in a systematic fashion and provide for the retention of this documentation in the patient's chart. The physician or office staff may contact Mia Woods at 720-858-6071 to obtain a supply of these record books free of charge.

To Meet Level One Guidelines

- All phone calls meeting one or more of the above bullet points are either attached securely as messages, documented in the medical record, or retained in a secure log book which includes dates and times
- Staff understands and can explain the practice's system

LEGIBILITY

The office record is a critical part of the physician's response to allegations of poor care. Therefore, the document must be legible to someone other than the writer.

To Meet Level One Guidelines

- Progress notes are dictated or electronically transcribed and therefore legible, or
- If handwritten, essentially all of the physician's documentation can be read without difficulty

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Practice Quality (from page 2)

MEDICAL RECORDS ALTERATIONS

Any questionable medical record corrections or additions, e.g., White-Out, black marker, notes in the margin, writing between the lines, erasures, etc., can be interpreted as altering the record and should be avoided.

The most effective way to amend an entry is to place a thin line through the incorrect information, note it as "error" and then initial. If only a single word or phrase needs to be corrected, that can be done at the point of correction if it is dated and initialed as long as the original entry remains readable. If longer, an entry should be included indicating where the corrected information can be found. Supplemental entries should include the date, time, and author's signature.

To Meet Level One Guidelines

- There are no questionable alterations in the chart and corrections are performed appropriately

INFORMED CONSENT

Informed consent requires that the physician obtain patient consent for treatment rendered, operations performed, immunizations, steroids, chemotherapy, etc. It is important that the patient understand the risks and benefits of a proposed treatment or procedure; alternatives to a proposed treatment or procedure; the risks and benefits of the alternative treatments or procedures; and the risks and benefits of doing nothing.

The following was taken from COPIC's Participatory Risk Management Program booklet as a guide to the areas for which physicians are being told they need informed consent:

Required

- All surgical procedures usually requiring general or regional anesthesia
- Any other procedure usually requiring general or regional anesthesia
- Cerebral and coronary angiography
- Endoscopy
- All sterilization procedures
- Any procedure where the usual risk is substantially increased because of some aspect of the patient's medical condition
- All plastic surgery procedures
- All surgical procedures upon the eye
- All surgical procedures upon the middle and inner ear
- Needle biopsy of internal organs
- Exercise treadmill testing
- Immunizations

Recommended

- Long term steroid therapy
- Long term anticoagulation

Not Mandatory, but recommended that there be at least a note in the clinician's documentation about the information provided and consent process

(However, consent forms would be beneficial for any future defense):

- Minor procedures generally done under local anesthesia (e.g., skin biopsy)
- Injection of contrast material
- Prescription/administration of the following drugs or drugs with similar problems: antibiotics which damage the eighth nerve; chemotherapeutic agents; and drugs commonly known to impact bone marrow adversely.

To Meet Level One Guidelines

- Documentation that an informed consent process took place and that, where appropriate, consent forms are signed by the patient and physician and are present in the chart (e.g., for surgical procedures, HIV testing and indicated medical treatments such as immunizations, steroids and chemotherapy)

PATIENT TRACKING AND REMINDER SYSTEMS

The presence or absence of office systems that function consistently can significantly affect the quality of medical care. Patient injury can result from systems failures even when there have been no errors in clinical judgment or treatment.

An appointment tracking system should determine whether a patient completes a follow-up appointment in the office as instructed. Most physicians, from time to time, have a patient who must return to the office. The conditions which may require a return visit include a breast mass, questionable Pap smear, borderline or abnormal test results, special medications or any finding for which the health care provider believes it critical that the patient be seen again. If possible, this should include patients who are discharged from the hospital with instructions to return to the office or a consultant for essential follow-up care.

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Practice Quality (from page 3)

To Meet Level One Guidelines

- Practice can demonstrate the existence and use of a tracking system to determine whether patients complete follow-up appointments as planned

TEST REPORT TRACKING AND CONTACT SYSTEMS

Test Tracking System for Labs, X-rays and Other Tests— A test and report tracking system should be implemented to assure that all "essential" diagnostic tests ordered (either done within or outside the office) or reports expected are completed. The system should alert one of missing tests or consultant reports or failure of the patient to follow through as requested. For instance, the system should track specimens that leave the office and orders generated from the office for diagnostic testing.

To Meet Level One Guidelines

- Tracking system exists for specimens that leave the office and for orders generated by the office for all "essential" diagnostic tests

Review of Incoming Reports— It is important for the practice to have a policy to ensure that lab/imaging/test reports, consultations and other pertinent documents are seen by the practitioner prior to being filed in the medical record. All reports must be reviewed and initialed by the reviewing practitioner (MD, DO, PA, and NP). If the physician designates someone else to review and sign test reports, protocols should be present for this.

To Meet Level One Guidelines

- Essentially all reports/consults are initialed by the reviewing practitioner prior to filing

Follow-up Contact System for Results of Labs, X-rays and Other Tests—A follow-up contact system ensures there is a mechanism in place to notify patients of test results (labs, X-rays and other tests), any further follow-up needed, and to document that this took place. Having a test/lab follow-up contact system may help patients better understand the meaning of test results and the need for follow-up care as well as reduce the risk of abnormal results not being communicated to the patient in a timely fashion. This task can be appropriately delegated to trained office staff, but important issues may need the physician's personal communication with the patient.

To Meet Level One Guidelines

- A follow-up contact system is in place to ensure that patients are notified of all abnormal test results and the needed follow-up and documentation supports that the patient was notified
- The office manager or office staff understands and can explain the Test Follow-up Contact System

In Closing

We believe the issues raised in the Level One guidelines are areas in which significant improvement in systems can change malpractice claims frequency, severity, and defensibility. We are dedicated to assisting our insureds to improve their office systems. This program is not intended to be yet another intrusion into your busy professional lives, but rather a way all our insureds can improve systems for the benefit of our patients and malpractice premiums.

All Physicians

Guidelines for COPIC Physicians Involved with Administering Vaccinations

Many people are now involved with administering vaccinations. Colorado is one of 33 states in which qualified pharmacists may administer vaccinations by authorization of a physician. {CRS § 12-22-102 (2001)} For anyone administering vaccinations there are some risks involved.

If you are involved in the administration of vaccinations (i.e., either by giving them yourself, having your staff administer them or sending your patients to a pharmacist to get them), it is recommended that you use the following to help mitigate your risk:

1. If you are using a pharmacist for this, make sure he/she is both qualified to administer vaccinations and is a licensed pharmacist in the State of Colorado. If a staff member in your office is performing these functions, make sure he/she is properly trained. It is suggested that they be directly supervised initially to ensure their competence and understanding of possible risks.
2. Make sure indications, allergies and possible risks of the vaccination (such as allergy to eggs, etc.) are properly assessed.
3. Document pertinent information such as patient's name, age, DOB, sex, contact information; the

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Vaccinations (from page 4)

vaccination type, manufacturer, lot number, route/site and number of previous doses. You should use the most recent education and consent form from the Vaccine Adverse Event Reporting System (VAERS) for this, documenting which edition of the form you used in your record. To view this, go to http://www.fda.gov/cber/vaers/vaers.htm or http://www.cdc.gov/nip/publications/VIS/default.htm

The specific requirements of Record Keeping per the Centers for Disease Control follow:

Health care providers shall make a notation in each patient's permanent medical record at the time vaccine that information materials are provided indicating (1) the edition date of the materials distributed and (2) the date these materials were provided.

This record-keeping requirement supplements the requirement of 42 U.S.C. § 300aa-25 that all health care providers administering these vaccines must record in the patient's permanent medical record (or in a permanent office log) the name, address, and title of the individual who administers the vaccine, the date of administration, and the vaccine manufacturer and lot number of the vaccine used.

4. We strongly recommend an informed consent discussion and documentation of this prior to vaccine administration to ensure patients and/or parents understand the risks and benefits of each vaccine given.The Colorado Health Department has developed specific forms for this purpose. In addition, further information regarding immunizations can be found at http://www.cdc.gov/nip/.
5. Put protocols in place to manage any emergencies or untoward effects that might occur.
6. Report any event to the VAERS, a cooperative program for vaccine safety of the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC). The National Vaccine Injury Compensation Program is a federal "no-fault" system designed to compensate those individuals, or families of individuals, who have been injured by childhood vaccines. Details of this program are available at http://bhpr.hrsa.gov/vicp/dvicprog.htm.
7. Any adverse event related to immunizations should also be reported to risk management at (720) 858-6127 or (800) 421-1834 ext. 6127.

3Rs Program Showing Proof of Value of Early Communication

COPIC Insurance Company embarked on a bold initiative in October 2000 when we launched the 3Rs Pilot Program to ***Recognize***, ***Respond to***, and ***Resolve*** treatment-related injury. **The main thrust** of the 3Rs Pilot Program is to facilitate early communication between a physician and a patient who has suffered a treatment-related injury; in addition, patients can receive disability payments capped at $5,000 and reimbursement for out-of-pocket expenses capped at $25,000.

Since the program's kick-off, more than 250 physicians have agreed to participate and have called in more than 75 incident reports. Not every incident qualifies for inclusion in the 3Rs pilot; the circumstances presented by some incidents require them to be handled by the Claim department.

Examples of the kinds of incidents handled under the 3Rs Pilot Program include:

- **Plastic surgery: abdominoplasty.** Post-operative breathing problems led to an unplanned hospital admission. COPIC facilitated communication among the physician, patient and the health insurer. Expenses under the program: $0.
- **Ophthalmology: LASIK.** Patient's vision remained at 20/80 following the procedure. COPIC assisted in the patient's follow-up evaluation and treatment. Expenses under the program: $5,500.
- **Gynecology: hormone pellet implants.** Abscess developed, necessitating further surgery, three months of IV antibiotics, and oral medications for one year. COPIC assisted with physician-patient communications and reimbursed patient for medications and home care. Expenses under the program: $2,125 to date.
- **General surgery: laparoscopy.** Lysis of appendectomy adhesions was complicated by a perforation of the small bowel, resulting in an unanticipated inpatient admission, conversion to an open procedure, and the need for parenteral nutrition and home health care. COPIC facilitated surgeon-patient communication, reimbursed the patient for lost work time, and intervened with the Commissioner of Insurance to assist with health insurer payment of costs associated with the complication. Expenses under the program: $5,400 to date.

According to Evonne Domoney, B.S.N, M.A., who manages the program at COPIC, the surgeon in the last

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3Rs Program (from page 5)

example feels the program was very helpful, providing important guidance and assistance in preparing for his meeting with the patient. The patient continues to receive care from the surgeon and reports great satisfaction with the speed and ease of obtaining benefits under the program.

Some important points to remember about the 3Rs Pilot Program:

- **The primary purpose** of the program is to preserve the physician-patient relationship through the use of clear, candid, early communication; reimbursement benefits available to patients are considered ancillary.
- The patient retains the right at all times to pursue legal action if desired; no waiver is sought or required as a condition of receiving program benefits.
- Participation does not limit your professional liability coverage, nor does it raise your premium.

If you are interested in participating in this unique and valuable program, please contact your Underwriter at (720) 858-6000 or (800) 421-1834. You will receive a packet of informational materials along with a letter of agreement for you to sign and fax back.

All Physicians

Current ERS Cycle Ends December 31

Physicians May Earn Point by Taking Enclosed Quiz

The 2000-2001 ERS cycle will end December 31, 2001. Risk Management sent letters to insured physicians at the end of September notifying them of the total number of points accumulated as of that date.

As a reminder, insureds with a full-time mature policy need to earn six ERS points for the two year cycle in order to qualify for the preferred rate (10% discount). Those who have earned two to five points for the cycle will pay the standard rate, and those with less than 2 ERS points are in the surcharge category (standard rate plus 10%). The corresponding numbers for part-time physicians are three points for preferred rates, one to two points for standard rates, and those with one point or less are in the surcharge category.

Physicians may earn points by attending risk management seminars. The last seminars for this year are printed on page seven in this issue of Copiscope, (if any additional seminars are scheduled after the print date of this Copiscope they will appear on the Web site). We recognize that some physicians may encounter travel difficulties, so we also offer ERS points via the 1999 and 2000 Copiscope quizzes (1 ERS point each; available online at www.copic.com). In addition, in this issue you will find a distance learning exercise based on COPIC's Participatory Risk Management Program booklet. All insured physicians received and acknowledged their participation in this program at the time of initial application and at each individual renewal date. Physicians may take this quiz and fax it back to Risk Management for one ERS point.

NEW NEW NEW NEW NEW NEW

Seminar: Using the Electronic Medical Record Benchmarks*

December 4, 2001
7:30 a.m. – 8:30 a.m.
Founder's Boardroom
COPIC Insurance Company
Continental breakfast will be served
RSVP to Stephanie at 720-858-6127 or (800) 421-1834 ext. 6127

This seminar, worth 1 ERS pt., is designed to enhance your use of the Benchmarks tool.

What others are saying about this seminar:

- *"With guidance, one could read and understand in a much shorter period. The content is very relevant."* D. Thomason, MD, Family Practice
- *"Wonderfully clear and concise. User-friendly, even for the non-computer-savvy. This begins to make the issue of EMR seem achievable and much less daunting."* G. Frey, MD, Gynecology

** Bring your copy of the EMR Benchmarks*