Objectives

- Explain the liability issues associated with expanded specialty scope of practice.
- Explore the risks in expanded scope of duties performed by various unlicensed personnel within a medical practice.
- Describe the risks and benefits associated with the implementation and use of electronic health records (EHR).

“Specialty Creep”

- Expanding specialty scope of practice
Contributing Factors

- Increasing costs of doing business and
- Decreasing reimbursement.
- Exploration of new revenue generating activities.

Introducing a Wide Array of New Services

- Use of lasers,
- Cosmetic procedures,
- X-rays,
- Office based surgeries,
- Dispensing medications, and
- The list goes on.

According to the Physicians Insurers Association of America

28% of all reported claims and suits for all specialties occur in the ambulatory setting.

The five most frequently sued specialties are:
- OB/GYN,
- Internal medicine,
- Family practice/general practice,
- General surgery, and
- Orthopedic surgery.
2006 Study by the Medical Group Management Association

Common errors in ambulatory care:

- 9% of patients taking medications require medical care for complications.
- 4% of the prescriptions written contain medical errors.
- 36% of mammogram results with marginal findings don’t receive appropriate follow-up care.
- 25% of referrals have no follow-up information 4 weeks later.

Perfect Environment for Medical Errors

- New procedures,
- Fewer established protocols,
- Unfamiliar patient populations, and
- Poorly trained personnel.

Importance of Quality of Care and Risk Management

- Studies indicate 70% of all adverse outcomes are preventable, and
- 100% of claims are easy to defend if proactive risk management principles are applied.
Education for the Expanded Scope of Practice

- Formal training – Residency or Fellowship
- Organizations specializing in training physicians to perform particular procedures, or
- Being mentored or trained by other physicians.

Beware of...

- Companies offering free or inexpensive courses designed to promote their equipment and demonstrate its performance.
  - These are introductory courses.
  - Helpful in giving a feel for the equipment and ease of use.
  - May not provide sufficient hands on training.

Bottom Line

- Physicians with expanded scope of practice:
  - Must be competent in the procedures they perform.
  - Will be required to provide evidence of training and demonstrated expertise in the related area of practice in the event of adverse outcome, claim or lawsuit.
In Addition to Education and Demonstrated Expertise

- Develop a business plan,
- Visit other practices with expanded services,
- Review professional organizations’ practice guidelines to ensure conformity to community standard of care, and
- Notify professional liability carrier.

Carefully Consider

- Written policies and procedures to promote safe delivery of pt care.
- Begin with a limited scope of service.
  - Confirm process is safe and pts are satisfied.
  - Then incrementally expand scope of services.

Patient Satisfaction

- Satisfied patients are
  - Easier to care for and
  - Less likely to sue.
- Dissatisfied patients
  - Often take more time to care for, and
  - Are more likely to become plaintiffs.
Informed Consent

- Provide pt with sufficient information to reasonably allow an informed decision.
- The more invasive or risky the treatment or procedure, the more detail necessary.

Two Recent Court Decisions

- Wisconsin Supreme Court and Maryland Court of Appeals
  - Clarified that proof of medical negligence is not required for plaintiffs to bring an informed consent claim.
  - Both courts reaffirmed it is the physician's or other healthcare clinician's duty to communicate “all relevant treatment alternatives.”

Patients' Right to Know

- The physician’s training and experience level in performing the treatment or procedure.
  - The skill level of the physician and staff are directly related to the risks.
- Any additional risks presented by performing a procedure in the physician's office.
Example: Cosmetic Procedures

- Cosmetic procedures are one area of expanding medical practice services.
- Many are performed in non-medical facilities, such as spas or salons.
- It’s becoming more common to offer these procedures in medical practices and “medi-spas.”

Performed in Medical Office or under “Medical Supervision”

- Patients often describe as a medical procedure.
- Carry same risk of litigation as any other medical procedure.
- If litigation pursued, the physician will need to provide evidence that standard of care was met.

The American Society for Dermatologic Surgery

- Survey found approximately 45% of dermatologic surgeons reported an increase in the number of patients needing corrective treatment for burns, splotching, irreversible pigmentation and scarring resulting from various cosmetic procedures.
Limited Training or Expertise

- May be more difficult to defend a claim or lawsuit if the physician’s primary practice area is not dermatology.
- May lead to difficulty evaluating and treating complications.

Reliance on Unlicensed Staff

- Contributing factors include:
  - Current economic factors.
  - Shortage of licensed nursing personnel.
  - Expanding scope of practice.

Procedures Using Conscious Sedation

- Consult Medical Board and Department of Health to determine applicable rules and licensure requirements in your state.
- When designating a “procedure room” have
  - Adequate space,
  - Easy access to patient, and
  - Auxiliary power source.
- Patient monitoring.
- Documentation.
- Plans for handling unexpected patient emergencies.
Before Expanding Your Medical Practice Consider…

- What clinical knowledge, judgment and skills are required to provide safe, competent services?
- What are the prerequisites and core education needed in terms of undergraduate and postgraduate education and clinical experience?
- Will the education received meet the standards and be recognized by an independent and formally accredited educational organization or institution?

Also Consider…

- How does the education compare to that of other physicians providing the same service?
- How will I obtain an assessment of new skills once training is complete and prior to beginning an expanded practice?
- Will I be capable of recognizing and dealing with any complications?
- How will I retain competence in the expanded specialty?

For Staff…

- Do staff have appropriate education and expertise to perform assigned tasks?
- How will staff’s competency be measured?
- Are staff adequately trained and monitored to ensure patient confidentiality?
Another Hot Risk Management Topic

Electronic Health Records

Electronic Health Records

Congressional Budget Office estimates 90% of physicians and 70% of hospitals will be using EHRs within the next 10 years.
- The American Recovery and Rehabilitation Act of 2009 is expected to increase use of information technology.
- Allocates $19 billion for technology improvements.

Technology Offers Benefits

- Quick access to data.
- Receive potential life saving alerts.
- Notification of completed studies and follow-up reminders.
- Easy transfer of records
- Electronic prescribing and renewal of medications.
- Improved legibility of the record.
Varying Degrees of Success

- To utilize EHRs to their full potential:
  - Invest time in planning and training.
  - Avoid pitfalls and manage risks.

Selecting an EHR

- Involve future users in the selection and planning process.
  - Input may lead to positive changes in the system.
  - May improve acceptance of the EHR.
- Review and, when necessary, redesign workflow.
  - The goal is to create an effective system which makes practice of medicine easier and less error prone.

Designate a Primary System Manager

- “Primary” doesn’t mean this is the only person who is knowledgeable about the system.
- Coordinates all selection efforts, implementation and utilization oversight.
- Should possess:
  - Basic knowledge of computers and system operation,
  - Willingness to keep abreast of changes and updates in the field, and
  - Be able to effectively organize large projects.
- Must work with and listen to staff.
- A good sense of humor wouldn’t hurt!
Talk to Other Practices with EHRs
- Are they happy with their vendors?
- What changes do they wish they could make?
- Visit related healthcare technology websites.
  - Certification Commission for Health Information Technology (www.cchit.org).
    - Recognized by DHHS as the certification body.

Examine Overall Workflow
- All systems should be reviewed.
  - Use "big picture" thinking.
- Focus on areas that are not functioning smoothly or efficiently.
  - For example – if filing doesn't work efficiently, there will still be issues related to scanning of documents in an EHR.
- Fix the problems before you implement a new system.

Back-Up System Data
- Should be done on a frequent, regular basis.
- Daily back-up with off-site storage can be an advantage over paper records.
- Discuss with vendors how back-ups will be completed.
  - Will back-up process include all data or just portions of the data?
Examples

Number 1.
- Physician relied on vendor’s “promise” of daily back-up.
- Vendor’s employee didn’t perform back-up on any of the data.

Number 2.
- Physician’s main and secondary servers went down.
- When back-up tapes used to reconstruct records – found that tapes were corrupted so pieces of data were missing.

How Will the Finished Product Look?

When considering various systems – look at the finished product.
- How will it appear to anyone trying to review the record?
- Is information easily accessed?
- How many screens need to be viewed to obtain basic information?
- Does the chart tell the story of the physician’s thought process for the plan of care?

System Security

- Obviously, systems should permit only authorized user to access records.
- It should also maintain a record of all access.
- Authorized users should only have access to those portions of the record relevant to their job.
- Systems should automatically log off after the station has been inactive for a specific period.
Encryption Capabilities

- Sending information electronically is becoming commonplace.
- Review processes for electronic transfer of information to ensure patient information is encrypted before transmission.
- No patient information should be transmitted electronically without appropriate security.

A Word about Vendors

- Technical support is critical to the success of your EHR!
- Ask for references and inquire about their satisfaction with support issues.
  - Response time for problems solving?
  - System capability for updates and changes?

Once Vendor and System Selected

- Design the program to fit the needs of YOUR practice.
- Develop policies and procedures to promote security, confidentiality and patient safety.
- Plan how you can support and utilize the system to include sound risk management principles.
Missed or Inaccurate Information

- Three main concerns
  - Previous data input not easily found.
    - Can be caused by a confusing template or data storage program.
  - Trended information located in one area of paper record (e.g., vital signs, lab studies, allergies) but various places in EHR.
    - Requires scrolling or located in section that is rarely accessed.

The Third Concern

- Inaccurate data input which creates “chart lore.”
  - Wrong information repeated again and again.
    - Perpetuated by self-populating fields.
    - Less likely to be corrected as it is carried into different sections and onto a variety of screens.

Integrity of Record Entries

- Whether electronic or paper - any appearance of an alteration is extremely difficult to defend.
- Information should be stored in a manner which can be retrieved and read but cannot be altered.
- Addendums should be made without obliterating or destroying the original entry.
Once again, whether paper or electronic, the record must be accurate. Policies and procedures are needed to ensure accuracy of the record. Build steps for proofreading in the data entry process. Clinicians and staff should all be accountable for the accuracy of the information entered.

Limited opportunity for physician to demonstrate “cognitive thinking”
- Critical to a correct diagnosis.
- May provide fields to document what the patient doesn’t have but omits specific information which allowed physician to formulate a working diagnosis.
  - Automatic default to “normal,” especially when a specific assessment is not likely to have been performed.
- System should make it easy to add extemporaneous notes when appropriate.

Allows physician to reproduce an earlier note or portion of a note.
- Easier to cut and paste history and physical exam findings from prior visit than to document current findings.
- Notes may appear “canned” when phrases or progress notes are repeated on successive office visits.
  - May suggest to a jury the care wasn’t individualized.
  - When evident over multiple visits the credibility of the physician and record may be called into question.
Automatic Prompts and Alerts

- Recommendations or alerts that pop-up on the screen.
- Interruptive prompts or alerts may require a documented explanation of why it was not followed.
- Non-interruptive prompts may be ignored or closed without additional documentation.
- Plaintiffs' attorneys will question “Why?” if prompts or alerts are ignored.
- Remember - they are there to “prompt” you to think.
  - Document reason(s) for override.

Security

- Passwords combined with varied levels of access help protect information from unauthorized access or tampering.
  - Strict enforcement of password security.
  - Confidentiality statements that include agreement not to share passwords.
  - Remote access via internet should be closely monitored.
- Access to records should be removed ASAP after employment ends.

In July 2009, the US Department of Justice and the FBI announced a physician and two hospital workers in Arkansas pled to misdemeanor violations of HIPAA. Each admitted to violating the information privacy provisions of HIPAA by accessing a patient's record without any legitimate purpose. They face a maximum penalty of 1 year imprisonment, a fine of not more than $50,000, or both. The US Attorney handling the cases stated, “The HIPAA privacy protections are real, and we hope that through vigorous enforcement of HIPAA’s right-to-privacy protections and swift prosecution of those who violate HIPAA, we can deter those in the medical industry who have access to protected health information from searching others' medical records merely to satisfy their own curiosity..."
What to Do with Paper Records?

- Scanning paper records into EHR.
  - Provides easy access to patient’s history.
- Combination of paper and electronic record.
  - Need to review both paper and electronic record may lead to workflow problems or reluctance to review paper records.

Imaging Paper Records

- Once electronically imaged, some practices and imaging companies destroy the original records.
  - EHR then becomes the “original” record.
- Important the vendor scanning the records provide a certificate or other document certifying:
  - All pages of the EHR are an accurate scanned reproduction of the original record.
  - Neither the paper record nor EHR were in any way altered or modified before or after imaging.

Authentic and Accurate EHR

- Electronically imaged paper records should include:
  - Same print size,
  - Color,
  - Any loose papers and/or post-it notes,
  - Handwritten notes on file covers, and
  - Writing on the front or back of lab sheet or other document.
Legal Discovery of EHRs

- Electronic discovery rules allow plaintiffs’ attorneys to request the raw data (metadata).
  - Metadata is embedded electronic data typically hidden from view.
  - Shows when user logged into system, what portions were reviewed and how long they were reviewed.
  - Shows what additions or changes were made, if any.
  - Shows when EHR was closed.

For Example

- Metadata can reveal a pop-up appeared and was closed seconds later.

Electronic Discovery

- Has the ability to:
  - Request emails (even deleted ones),
  - Not just on office computers but also on iPhones, PDAs, Blackberrys and other types of communication devices.
Key Risk Management Points

- Take time to carefully plan new services.
- Acquire the knowledge and skill to proficiently perform new procedures or treatments in a competent and safe manner.
- Adequately inform patients of the risks, benefits and all alternatives of the service offered.
- Identify areas needing improvement with a formal program by tracking patient outcomes and results of patient satisfaction surveys.

Key Points

- Establish scope of job responsibilities for unlicensed and non-clinical staff.
- Take time to carefully research and plan for an EHR.
- Select and maintain an EHR that is patient-centered, physician-friendly and risk management focused.
- Select a primary system manager to coordinate selection, implementation and utilization.
- Monitor EHR utilization to be sure policies, procedures and protocols are followed.

Questions?