Advocate MD™

Fall 2006

Advisor

THE TEXAS PHYSICIAN'S ADVOCATE

Advocate, MD Earns Perfect Score from TDI

On Aug. 17, 2006, the Texas Department of Insurance conducted a comprehensive evaluation of the Advocate, MD Insurance Company in Austin, Texas. We're proud to announce that Advocate, MD received a perfect score.

TDI performed the survey to determine the adequacy of Advocate, MD's risk management and loss control program, and our ability and competency to serve our policyholders.

The state's evaluation included a comprehensive document review as well as interviews with our Risk Management and Claims Management staff. The reviewer focused on the company's corporate structure, support for the provision of loss control, and how well we met the policy and procedural requirements of the State of Texas in accordance with TIC and Title 28.

Areas of particular interest for the survey were:

- **Operating procedures**
- **Loss control activities and communication**
- **Appropriate loss control methods and analysis**
- **Training programs and qualifications of loss control representatives**
- **Effective and timely communication with insureds**

This survey identified a high level of activity and support documentation, a strong indicator of the quality of the loss control work we perform.

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The Power of an Apology

By Stewart Stimmel LLP

Traditionally, health care providers have responded to allegations of bad outcomes with a "deny, dispute and debate" posture, refusing to admit that a medical error might have contributed. Today however, a slow revolution is occurring: Some providers are working to reach fair, nonadversarial resolutions to medical errors associated with bad outcomes.

A coalition of medical stakeholders, including physicians, lawyers, hospital administrators and legislators, has created an initiative called "Sorry Works!" The initiative promotes apologies as effective risk-mitigation tools, and several state legislatures have enacted or are considering legislation to prevent providers' apologies from being used against them in court.

However, the solution is not simply to apologize and walk away. Critical parts of the process are a careful investigation of the bad outcome and a thorough analysis of whether medical error played a role. If medical error was involved, a four-step resolution is appropriate:

1. **Admit error**
2. **Explain what contributed to the error and what changes will occur to prevent the error from recurring in the future**
3. **Express remorse**
4. **Propose a reasonable up-front settlement**

This process requires open, honest and compassionate communication with the patient and/or his or her family members.

An honest dedication to determining whether a medical error contributed to a bad outcome, and to preventing future errors, helps allay concern that a similar problem will occur again. At the same time, reasonable up-front compensation for losses diminishes the appeal of a malpractice recovery.

In the end, a properly implemented "sorry" just might be what patients and their family members need. ★

HIPAA Helpfuls

DOES THE HIPAA PRIVACY RULE GIVE PARENTS THE RIGHT TO SEE THEIR CHILDREN'S MEDICAL RECORDS?

The HIPAA Privacy Rule gives parents the right to have access to and see their children's medical records, as these records pertain to their child or as their minor child's personal representative.

There are three situations when the parent would not be the minor's personal representative under the Privacy Rule. These exceptions are:

1. *When the minor is the one who consents to care and treatment, and the consent to care is not required under state or other applicable law*
2. *When the minor obtains care at the direction of a court or a person appointed by the court*
3. *When the parent agrees that the minor and the health care provider may have a confidential relationship*

However, even in these exceptional situations, the parent may have access to the minor's medical record related to this treatment when state or other applicable law requires or permits it. Parental access would be denied when state or other law prohibits such access. If state or other law is silent on a parent's right of access, the licensed health care provider may exercise his or her professional judgment, as allowed by law, to grant or allow access to the minor's medical information.

Finally, as is the case with all personal representatives under the Privacy Rule, a provider may choose not to treat a parent as a personal representative when the provider reasonably believes that the child has been or may be subject to domestic violence, abuse or neglect, or that treating the parent as the child's personal representative could endanger the child.

CAN A PHYSICIAN'S OFFICE FAX PATIENT MEDICAL INFORMATION TO ANOTHER PHYSICIAN'S OFFICE?

The HIPAA Privacy Rule permits physicians to disclose protected health information to another health care provider for treatment purposes. This can be done by fax or by other means.

Covered entities must have in place reasonable and appropriate administrative, technical and physical safeguards to protect the privacy of protected health information that is disclosed by fax machines. Examples of measures that could be reasonable and appropriate in such a situation include the sender confirming that the fax number to be used is in fact the correct one for the physician's office, and placing the fax machine in a secure location to prevent unauthorized access to the information.

For more information about HIPAA privacy rules and other HIPAA related questions, visit www.hhs.gov/ocr/hipaa. ★

Schedule Your Complimentary Risk Assessment and Loss Prevention Survey

Want to be sure you're doing everything you can to protect your practice? Schedule a free Risk Assessment and Loss Prevention Survey today.

Advocate, MD provides this complimentary service to any interested policyholder. Simply contact **Terrence G. Hurst, CPHRM, MHA,** at Advocate, MD. The assessment involves an on-site visit by Advocate, MD's Director of Risk Management, interviews with physicians, and close interaction with your practice or office manager and other staff members as appropriate.

The assessment is a customized, definitively outlined process covering more than 200 points of a medical practice and its risk exposures. In most cases, a thorough review of 10 or more randomly selected files is conducted. At the conclusion of the survey, the Director of Risk Management will meet with the physicians and staff to review the preliminary findings and outcomes.

Advocate, MD believes that a proactive approach to risk management is essential to controlling risk and losses, and provides a focus to help physicians provide safe, high-quality health care. ★

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NEED ANSWERS?

Contact Advocate, MD to have your questions addressed in our next issue of the Advocate, MD Advisor. We have an experienced and knowledgeable staff ready to answer any question you may have. Also, please contact us if you would like to submit an article, testimonial, story, or suggestions that may benefit other policyholders.

We value our policyholders and would like to extend an opportunity to help you further.

If you would like to receive updates and our quarterly newsletter via email, please send a request to **marketing@advocatemd.com**.

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Proper Documentation: Why You Need the Habit

By Mitch Dean and Brandon Kulwicki, Stewart Stimmel LLP, Dallas/Houston

Documentation in medical records is a daily task for every physician. Like any daily task, it can become rote, and its importance can seemingly be diminished by repetition. A prudent physician will guard against this tendency and vigilantly create and maintain a focus on good documentation techniques.

This is the first in a series of documentation articles that aims to provide a new perspective on documentation. The goal of this article is to provide some practical considerations regarding the consequences of documentation, including not only liability exposure, but how good documentation makes good business sense. Future articles will address good documentation habits.

REPUTATION AND PATIENT SATISFACTION

Medical records do not exist in a vacuum, and documentation is not a process done for its own sake. Rather, medical records serve the important function of communication — to the patient, other providers, payers, interested third parties — and yourself. Think about it: There is no excuse in not being able to understand or trust your own documentation.

Physicians work for patients. Physicians need patients. Fulfilling the patient's expectations is clearly an important component of securing and keeping new patients. While pleasant bedside manner and positive medical experiences are paramount, documentation is another determining factor. Patients can and do see their medical records. Sloppy, hard-to-read, inaccurate and incomplete documentation can be a source of dissatisfaction for patients. Comprehensive documentation shows attention to detail and helps convey the impression of a competent, caring physician.

A physician's reputation within the medical community is as important as his or her reputation among patients. Most physicians rely on referrals to develop and maintain a practice. Each of you has received illegible and incomplete records from physicians who have treated your patients. When that happens, you are less likely to make future referrals.

Similarly, you are less likely to accept referrals from poor documenters. Failure to properly document can lead to misinformed and uninformed decisions by other providers that may not only jeopardize the patient's well-being, but subject the subsequent provider to embarrassment and potential liability. Both of those outcomes are to be avoided and are reason enough to properly document.

THE DREADED LAWSUIT

The threat of litigation hangs over the head of every physician like Damocles' sword. The quality (or lack thereof) of the documentation in medical charts absolutely affects whether a lawsuit is ever filed.

Before a lawsuit is filed, the attorney will review the patient's medical records in great detail. If the medical records are incomplete, sloppy or illegible, an attorney may be inclined to file a claim, notwithstanding the quality of the care provided.

With sloppy, incomplete, illegible records, the issue is no longer whether the care is appropriate or not, but whether — based upon poor records — the care can be made to seem inappropriate. Poor documentation does invite litigation. Attorneys routinely argue that poor documentation is a precursor of carelessness and lack of concern. Attorneys do argue that things not documented in records did not occur. This can turn an otherwise weak claim into a strong one.

And then, when the inevitable deposition occurs, the physician who cannot read his or her own entry loses the all-important aura of credibility before the jury. When credibility is lost because of poor documentation, the argument that quality care was given starts to ring hollow.

In addition to attorneys, the Texas Medical Board will take a long, hard look at documentation practices. Good care not properly documented can result in an adverse Board Order. Board Orders have long-range consequences, including the potential to lose participation in various third-party payer plans.

Conversely, proper documentation does deter lawsuits. If the records are clean, legible and complete, an attorney might decide against filing an otherwise weak claim. This may become especially important with respect to informed-consent cases.

Having a clearly documented and retained informed-consent form signed by the patient, can determine the outcome of some lawsuits, in addition to being required by law in many instances. Conversely, the absence of such documentation when treatment requires informed consent — whether by statute or general consent principles — can be outcome-determinative in proving a health care liability claim.

This does not suggest that medical records should be white-washed. If an unfortunate event occurs, a physician should not destroy documentation of it. Nor should the physician intentionally avoid documenting something that should otherwise be recorded.

The failure to properly document or retain records can lead to other legal concerns. For instance, the legal concept of "spoliation" comes into play when documents are intentionally destroyed or lost. The doctrine permits a legal presumption that the destroyed document contains information unfavorable to the physician — even if it did not. Some states (not including Texas) even allow for the recovery of monetary damages in a spoliation case.

Furthermore, the failure to document something negative can lead to a claim of "fraudulent concealment." Typically, lawsuits must be filed within two years of the specific event. That two-year period can be extended indefinitely when there has been fraudulent concealment through failure to disclose or document a negative medical fact.

In sum, failure to properly document does lead to negative liability consequences.

FINANCIAL BENEFITS

The time and energy spent using proper documentation techniques will have a positive financial benefit. As noted, proper documentation will advance a physician's professional reputation, which leads to a more lucrative practice. Moreover, it can help diminish the likelihood or extent of liability claims, which place significant financial burdens on physicians.

But beyond that, there are further financial benefits. Most physician practices rely on third-party payers, including insurance companies, HMOs and governmental agencies. Reimbursement or payment from third-party payers is maximized through proper documentation. Payers that are given the necessary information to satisfy their needs will be hard-pressed to find valid grounds upon which to deny payment. Poor documentation will result in a denial almost every time. Simply stated, proper documentation enhances the revenue stream.

Documentation methods run from basic hand entry to complex and expensive computerized systems. Without regard to which method is chosen, a physician can be sure that the time and money invested in documentation will be returned in multiples through enhanced third-party payments, patient and referral physician satisfaction, and frustration of attempts by attorneys to bring suit. And, let us be honest, frustration of attorneys is its own reward.

While documentation can be rote, it is still important. A concerted effort to engage in proper documentation techniques is a simple and efficient way to maximize and protect a physician's practice and increase the quality of care rendered. ★

Advocate, MD Web Based Education

Continuing medical education courses are just a click away with Advocate, MD's online resources for physicians.

Director of Risk Management, Terrence G. Hurst, C.P.H.R.M., M.H.A., has established a web-based education system that gives Advocate, MD-insured physicians and others access to more than one hundred hours of accredited medical education courses — all with a simple click on the Advocate, MD web site.

The system enables physicians to keep abreast of the many risk management and medical practice related issues that are so important to preventing and reducing claims, while helping to improve practice quality.

The web based system is easy to use and access, with contemporary content. It gives physicians an alternative to "live" presentations, allowing them to avoid long trips by using a comprehensive and useful tool that meets CEU and CME licensure requirements — right in their own offices.

To access the courses, go to the Advocate, MD web site at **www.AdvocateMD.com** and click on the Risk Management button. A link will open entitled "Accredited Continuing Medical Education Classes." Simply click on it and select from the list.

Physicians can select the course they need, take the course, and then take an exam covering the course content. The exam is graded and scored, and if a passing grade is achieved, the physician will receive a written certificate by mail.

For questions or help, please contact Terry at **512 | 275-1836**. ★

If You Receive a Notice of Claim, Act Fast

By Brenda Freeman, JD, Director of Claims Management

Medical malpractice claims are difficult to predict and can follow any number of routes to resolution. Often the route that a claim takes depends upon the timeframe within which we have an opportunity to review the notice of claim.

Each month we receive a substantial number of notice of claim letters that have no merit whatsoever. This means that our insureds are frequently subject to allegations of malpractice that cannot be substantiated by the claimant. Our goal is to practice "preventive medicine" through an early investigation and evaluation of each claim.

60 DAYS TO INVESTIGATE

Chapter 74 requires that the notice of claim be sent 60 days before the filing of a lawsuit. Thus, it is important that we receive the notice of claim promptly so that we can take full advantage of opportunities to investigate and evaluate the claim prior to the running of the 60 days.

Upon receipt of the notice of claim, we thoroughly review and evaluate the claim and make every effort to ensure that it is our insured who determines the route that the claim will take rather than the claimant. We accomplish this goal by immediately acknowledging the notice of claim and advising the claimant attorney that we will treat the 60-day period as an opportunity to collect more information.

This process has worked well for our insureds because our prompt and thorough attention to even a mild complaint often helps prevent an escalation of emotions. We are highly cognizant of the fact that when a complaint is ignored, even a minor complaint can become a lawsuit. Thus, a prompt response is needed.

THOROUGH INVESTIGATION WARDS OFF LAWSUITS

There are several routes that a claim may take. The preferred route is to work diligently to prove to the claimant attorney that the claim and allegations against our insured have no merit. We have been quite successful in taking that route recently.

Our success is based upon the fact that we perform a thorough investigation and evaluation of the claim during its initial stage. After our evaluation, we meet with the claimant attorney and provide documentation to support our insured. As a result of this proactive approach, numerous claimants have decided not to pursue their claims. And, we are confident that the claims will not be pursued based upon the fact that the statute of limitations has now expired on those claims.

There are also claims that cannot be evaluated within the 60-day period. However, that does not mean that those claims must immediately take the route of a lawsuit. Instead, we advise the claimant attorney that we are continuing to review the documents and request that no lawsuit be filed until we have had an opportunity to complete our investigation. We usually have this option available to us unless the statute of limitations is about to expire.

Our prompt and thorough attention to even a mild complaint often helps prevent an escalation of emotions.

Our goal is to prevent a claimant from pursuing the litigation route until our insured has had the benefit of our review and evaluation of the claim. We prefer to review, evaluate and investigate a claim prior to litigation than to do so under the constraints mandated by the court system.

We are seeing that this process is working to our advantage by virtue of the fact that there have been a tremendous number of claims that have not been pursued. Another great advantage has been the fact that those claims which should take the settlement route have been settled immediately without the necessity of a lawsuit.

The number of claims we have identified as worthy of an immediate settlement has been very small. We have initiated pre-suit settlement in only seven claims during the past year. In each of those seven claims our insured made a written request to settle after thoroughly reviewing the documentation and expert reviews that we obtained.

We do not hesitate to recommend an aggressive defense to a lawsuit. Cases that will be vigorously defended and tried are identified early, and our aggressive strategy is developed and followed. Our defense counsel is composed of highly experienced attorneys throughout the state. These experienced attorneys have been highly successful in having lawsuits dismissed in favor of our insureds. As a result, most of our lawsuits hit a dead end shortly after being filed.

CONTACT US IMMEDIATELY IF YOU RECEIVE A NOTICE OF CLAIM

I would like to encourage all of our insureds to contact Advocate, MD immediately upon receipt of a notice of claim or anytime a question arises. It is our goal to be in control of the route a claim will take. The key to determining which route a claim will take is frequently in the timeliness and manner in which Advocate, MD responds on your behalf.

However, there is another reason why timely reporting is so important. It gives you a sense of relief. That is the message I recently received from the wife of one of our insureds:

"My husband was so relieved after talking with Advocate, MD. We were so impressed with the quick response that he received. Advocate, MD contacted my husband immediately, and an attorney was engaged to assist in responding to the notice of claim. Most important was the fact that the attorney met with my husband within two days. After meeting with the attorney and reviewing the documents, we both felt a sense of relief ." ★

Is Your Office a Source of Infection in the Community?

No! The sky isn't falling, and unlike Chicken Little, we aren't running around in a panic. Should we panic? No! But as providers of healthcare services, charged with and trusted with the health and lives of patients, we need to take seriously the role we play as a link in the infection control chain.

In the past few years, new pathogens have presented themselves, and some old ones have returned in a new and improved version. Avian Influenza H5N 1, SARS-CoV, measles, TB and MRSA, to name a few have worked their way into our lexicon, as well as our patients and their lives. They have caused incalculable harm and destruction to patients, especially the old and the young, and particularly those in a weakened state or those recovering from illness and or surgery. Hospitals have made infection control a high priority, and the reporting of infection rates by hospitals is now public information.

Once occurring almost exclusively in the acute care environment, MRSA, or Methicillin Resistant Staphylococcus Aureus, is now found among the general population. *The New England Journal of Medicine* (Aug. 17, 2006 issue) reported that MRSA is significantly underreported, as it is often misdiagnosed as other skin eruptions or lesions, or even spider bites that do not heal.

Infection prevention and control is an integral part of the medical practice in the outpatient setting and must not be disregarded in the belief that "infection control is the hospital's responsibility." Healthcare professionals should be knowledgeable and vigilant regarding the precautions and preventative controls for effective infection control in the medical office setting.

INFECTION CONTROL PRACTICES YOU CAN IMPLEMENT

Advocate, MD believes strongly in a proactive approach to risk management and loss prevention, and recognizes the importance of infection control. That's why we present the following routine infection control practices for your review and implementation:

- **Universal precautions and routine infection control should be in place and used for all patients, at all times. Do not assume or presume the infectious status or diagnosis of any patient.**
- **Review the office's physical layout and design, and provide a segregated area for patients with known contagious conditions. When possible, schedule those infectious patients when there may be a limited number of other patients in the office.**
- **Enforce strict adherence to hand washing before and after every patient contact. This cannot be overemphasized and is the single most effective infection control practice. Exam rooms should all be equipped with a sink and antibacterial soap. When sinks aren't available, an alcohol-based antiseptic is also effective.**
- **Gloves should be used as additional protection, but never as a substitute for hand-washing.**
- **PPE (commonly known as personal protective equipment) including gowns, masks and eye protection should be the norm and worn during any patient encounter likely to generate splash or spray of any body fluid.**
- **Needles, syringes and sharps should be disposed of in appropriate containers and never in the municipal waste path. Remember to get manifests from the contractor handling the infectious material.**
- **Appropriate cleaning, sterilization and disinfection of reusable medical equipment is essential. Perform the necessary preventive maintenance on the sterilization units and maintain records.**
- **Make certain that the cleaning staff is aware of the need to practice safe handling of all materials and waste from the office. Review the various cleansers and solutions that are used to ensure that the cleaning process is effective (not just pushing the germs around).**
- **Pediatric practices should be especially vigilant to ensure proper cleaning of any toys or other play devices that are commonly found in waiting areas.**

Infection prevention and control is an integral part of the medical practice in the outpatient setting and must not be disregarded in the belief that "infection control is the hospital's responsibility."

Because the practice of providing health care has become highly technological and scientific, we have a tendency to overlook the simple and obvious. As health care professionals, it is important that we recognize our role in controlling infections and providing our patients with a safe, healing experience. A solid infection control policy, enforced consistently, will provide this and make a safer work environment for ourselves, our employees and our families. Infection control is just good risk management and loss control. ★

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