RXNT

Mitigating risks for medical practices:

Just what the doctor ordered

As a practice, a large portion of your day is spent managing and mitigating risks. Whether these risks are anticipated or unexpected, they inevitably open your practice up to the potential of medical malpractice claims. These claims may include allegations regarding documentation, informed consent, diagnosis, privacy, confidentiality, and patient care.

It's often said the best risk management plan for physicians is evidence of good medical care. Let's walk through the most effective and efficient ways to create and maintain this evidence in common scenarios for physicians who own ambulatory care practices. We'll take a closer look at the current state of medical malpractice, three significant areas of risks, and effective ways to mitigate those risks.

Medical malpractice: Insights and current trends

In 2016, a John Hopkins study made waves with its estimation that, in the United States, 250,000 deaths per year are caused by medical errors. Here are some facts:

- Since 2009, approximately $38.5 billion has been paid out to plaintiffs in medical malpractice lawsuits in the United States
- Payouts for medical malpractice lawsuits averaged $309,908 from 2009 to 2019
- On average, family physicians are sued once every 7 to 10 years

There are many different types of medical malpractice claims. We often think of medical malpractice claims as "surgery gone wrong." However, the most common medical malpractice claims will hit home with physicians in an ambulatory care setting: failure to diagnose, delaying a diagnosis, and misdiagnosis. Recent studies indicate 52% of these claims relate to lab testing errors, including ordering the wrong test. Another 33% of claims relate to physicians failing to evaluate patients and their family health history. For family and internal medicine physicians, breast cancer, appendicitis, lung cancer, colon cancer, and myocardial infarction present the highest risk for malpractice lawsuits.

Negligence is another common claim, which encompasses ambulatory care settings and outpatient procedures. Many of these claims center around physicians and staff performing routine procedures while tired, sick, distracted, or otherwise unwell. Documentation presents another risk to contend with, especially around informed consent and Patient Health Information (PHI). Poor documentation and control methods open up the doors for malpractice claims.

The global pandemic, COVID-19, also presents greater challenges, risks, and concerns for the healthcare industry.

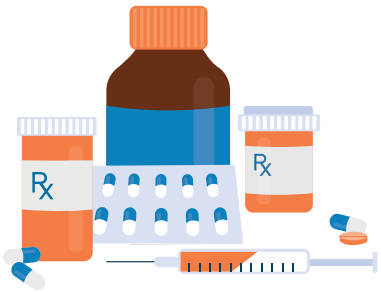
Ambulatory care providers are under immense pressure to quickly refer patients with COVID-19 symptoms to testing centers. Determining which patients need to be admitted to the hospital and which can recover at home under supervision presents a significant risk.

Malpractice claims around failing to diagnose and admit are seen often. Healthcare providers must also grapple with infection control. Not only is it crucial to keep yourself and your staff healthy, you must also take care to prevent the spread of the virus to patients who visit your practice for other healthcare concerns.

While risks for medical malpractice will continue to evolve, owners of medical practices should pay special attention to the following three challenges.

1. Prescription and lab testing risks

Each year, medication errors occur during 3.8M hospital admissions and 3.3M outpatient visits in the US.



According to the United States Food and Drug Administration, approximately 1.3M people are injured as the result of medical errors each year. Cardiovascular medications, analgesics, and hormones ranked highest in the study. Physicians are at risk for malpractice claims when these medication errors can be linked back to prescription and administration issues. In particular, allegations may be made regarding the physician's failure to assess the medication's known side effects, relationship to and potential interaction with other medications taken by the patient, or any benefits and risks of the medication in relation to the patient's overall health.

Physicians must consider the patient's allergies to medication, past adverse reactions, and common foods or beverages that may be consumed by the patient. Well-documented, accessible patient history is critical in these scenarios.

24% of all medication-related claims involve opioid analgesics, particularly in the case of overprescription. Follow-up consultations present greater room for error with prescribers continuing "to renew prescriptions without being able to monitor prescribing history from other physicians' patients" and failing to "track any changes in their clinical status to prescribe accordingly."

While healthcare providers often focus on potential errors during the prescription and administration of medication, errors of omission are also a concern. Failing to prescribe medications that improve patient health and well-being presents room for malpractice allegations.

Lab tests also present a risk for malpractice claims and the effects of repetitive and unnecessary testing procedures are often misunderstood. Not only are repetitive tests often the cause of reimbursement denials, they can also delay diagnosis. Patients miss vital test when instead they are tested incorrectly or unnecessarily. Failing to select the right test, inaccurately interpreting test results, repeating tests, and not communicating results to the patient are all potential avenues for medical malpractice claims.

Navigating prescription and lab test challenges

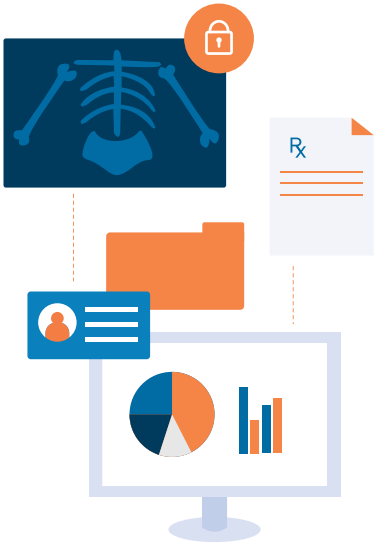
In the case of medication errors, Electronic prescribing tools can help physicians track patient use, response, potential "doctor shopping," and potential risks. While jokes around doctor penmanship have persisted for decades, illegible handwriting can put physicians and patients at risk.

According to the Institute of Medicine, over 7,000 patient deaths are caused by illegible penmanship and prescription filing errors. Between 2004 and 2014, the estimated cost savings for practices that used E-Prescribing are between $140 billion and $240 billion. These cost savings translate to fewer patient visits and better outcomes.

According to SureScripts, e-prescriptions are quickly and legally becoming a necessity with over half of all states requiring electronic prescribing for opioids, controlled substances, and even all prescriptions. However, not all E-Prescribing systems are the same.

To mitigate the risk of medication errors most effectively, providers should opt for systems that integrate and house the following in one convenient location:

- Patient medical histories
- Electronic prior authorizations
- Insurance plan formularies
- Pharmacy benefit managers
- Electronic prior authorizations
- Patient benefit coverage
- Reminders for follow-up visits and refills
- Patient education
- Claims history
- Alerts for potential drug-to-drug, drug-to-diagnosis, and drug-to-allergies reactions



Electronic Health Record (EHR) systems can also help physicians track tests and lab results, and maintain records of them both. Integration with a patient portal allows patients to review their results, communicate directly with their doctor regarding the results, and ask questions. EHR systems file lab results directly into the patient's chart for accessibility and clarity. Implementing a transparent, electronic system allows providers to reduce the risk of duplicate tests, lost results, and misplaced lab orders.

2. Telehealth and virtual care concerns

90% of healthcare organizations in the U.S. currently use or plan to implement telehealth.

Telehealth has become an important means of providing greater access to healthcare. With the recent COVID-19 pandemic, telehealth platforms have allowed physicians to treat patients effectively while curtailing the spread of the virus.

However, with new forms of healthcare come the potential for medical malpractice claims. The sheer number of ways to provide telehealth services (from videoconferencing to digital medical devices) can lead to confusion around compliance, state regulations, and standards for medical practice.

Physicians must take care to maintain informed consent procedures in a virtual setting. Relying heavily on paper forms or practicing poor e-documentation raises the risk for medical malpractice allegations. Likewise, physicians must maintain accurate records regarding telehealth services, including the technology used.

Some of the potential risk regarding telehealth lies in patient location. Perhaps the largest benefit of telehealth for patients is being able to access a healthcare professional no matter their location. However, physicians are limited to practice only in the states where they are licensed.

Physicians must be aware of patients who live out of state, particularly those who live close to neighboring state lines. Providers should also track which of their patients travel often or live outside the state for a significant portion of the year. It's critical that physicians not only stay up-to-date on licensure requirements, but also know the location of patients at the time of telehealth appointments.

With more of the practice being moved online, the risk of cybercrime also increases. This activity includes data breaches, stolen medical records and Patient Health Information (PHI), online scams related to medical concerns, phishing, and even, "Zoom-bombing." Medical devices and wearables may also provide openings to access PHI housed in provider networks.

Look no further than the recent attack on the United States US Health and Human Services Department's computer system. Fake text messages were sent from the department's Twitter accounts. These tweets stated that a national quarantine was effect for two weeks; spreading misinformation and causing public outcry in just a few characters.

Be proactive about telehealth and virtual care risks

First and foremost, telemedicine must always meet HIPAA requirements. Steps to maintain patient confidentiality and privacy should be taken. Any telehealth technology must be secure, encrypted, and fully compliant with HIPAA. Many consumer-based video-conferencing tools such as Skype, Zoom, and Facebook Messenger fail to meet these requirements and should be avoided.

Telemedicine providers should have comprehensive, accessible documentation about their platform's compliance with HIPAA and PIPEDA. Furthermore, they should be willing to enter a business associate agreement (BAA), provide fully-encrypted data transmission, and secure peer-to-peer network connections. Physicians should also understand where any PHI is stored, including audio and video recordings from patient sessions.

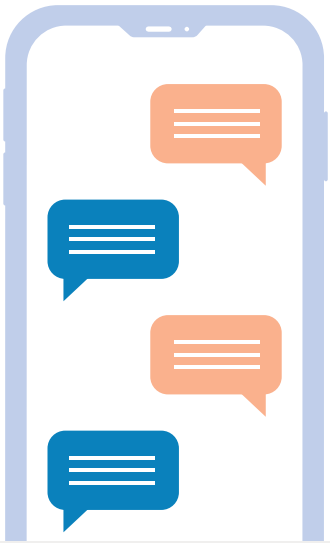
For greater efficiency, physicians must ensure any platforms they use to manage their practice are telehealth-friendly. In other words, you should be able to document virtual interactions with patients into your EHR system and file claims remotely. Integration with your patient portal is also critical so patients can schedule appointments, send secure communications, and access paperwork prior to their telehealth appointments.

Your EHR system should also support virtual follow-up care appointments. Automated reminders can help you keep patients on track with flu shots and vaccinations. Likewise, alerts prevent adverse reactions before they occur.

3. Potential issues with documentation and records management

Communication failures are a factor in 30% of medical malpractice cases.

In today's world of information overload, it isn't uncommon for ambulatory care practices to be burdened down by data. This data may be housed in multiple locations and siloed from providers. This information must be captured, documented, and stored correctly in order for healthcare providers to use it effectively and meet standards of care. Electronic Health Records should detail the services provided, staff involved, their credentials, as well as the devices and technology used in patient care.



Robust documentation and strict adherence to protocols are particularly important to avoid malpractice claims. Documentation supports compliance to proper standards of care, informed consent, and patient acknowledgment. Physicians should maintain evidence of cross-checks and review potential drug effects and interactions for their patients.

In recent years, digital photographs, fingerprints, and biometrics have helped physicians and staff identify a patient and inform their care through medical and family history. These solutions can mitigate patient identification issues when utilized correctly.

Addressing documentation and record management concerns

EHRs have become the standard for ambulatory physicians with an adoption rate of 86%. EHR systems house healthcare documentation in an accessible, convenient location, serving as a single source of truth for the practice. The documentation of healthcare activities can serve as evidence and protection during the event of a medical malpractice suit. EHRs allow physicians and their staff to establish records of who has accessed medical records. They also protect PHI from prying eyes and help to establish audit trails.

Likewise, the automation of patient paperwork and informed consent documents safeguards the privacy of the patient while introducing greater efficiencies into the practice. Patients can take charge of their health with patient portals and maintain greater communication with their providers. EHRs with mobile patient check-in cut back on time spent in the waiting room.

According to the Office of the National Coordinator for Health Information Technology, EHR systems can help reduce "the fragmentation of care by improving care coordination." Distributing health information among providers is key to a comprehensive picture of a patient's health status. This information is especially important in the case of emergency department and specialist visits. Providers can review the current conditions of a patient, any preventive measure they may be eligible for, their current medication, and lab test results. EHRs allow multiple authorized providers to work together to manage risk factors and health conditions to improve patient outcomes.

Documentation requirements are time-intensive and taxing on resources. While EHR systems have cut down significantly on time spent on documentation, they are not all created equal. According to the American Medical Association, physicians spend an average of two hours on EHR documentation for every hour spent with a patient. The ideal EHR includes tools for workflow documentation, integrated with a patient portal, customizable templates, and secure data exchanges.

Finally, EHR systems allow physicians to increase the efficiency of their practice and the productivity of their staff. Electronic workflows and documentation can be used to highlight impediments and room for process improvements.

For over 20 years, RXNT has provided secure, reliable, and integrated healthcare software to help physicians mitigate risks and improve patient care. In these times of change and unprecedented demand, we're here to support your practice with modern technology solutions that meet regulatory standards and mandates.

For a look at how RXNT can help safeguard your practice, sign up for an easy, no-pressure virtual demo.