



Covering Practice and Risk Management Issues for Physicians

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Stephen Scheifele, MD,
Executive Editor
Robert D. Nachtigall, MD,
Editor

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Physicians Reimbursement
Fund, Inc.

711 Van Ness Avenue
Suite 430
San Francisco, CA 94102
(415) 921-0498 - voice
(415) 921-7862 - fax
June@PRFrrg.com
www.PRFrrg.com

June Riley, MBA
Executive Director

Soad Kader
Director of Membership

DIRECTORS
George F. Lee, MD
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Damian Augustyn, MD
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PRF Analysis Shows Top 10 Claim Areas

Physicians Reimbursement Fund, Inc. is creating a computerized data base of its claims data, which will improve PRF's risk management services.

The project will allow PRF to sort and analyze all claims data since the company began providing malpractice coverage 30 years ago.

A preliminary review of the data shows that in the past 30 years there were 394 claims for which the PRF expended more than \$500. Of those 394 claims, 80 percent were in ten areas, as shown in the

table below. The monies spent in the 394 claims may have been for Code Green, defense, or settlement costs, or to pay arbitration or jury awards.

The rankings in the table were based on the number of claims and not by cost per claim. The type and frequency of the claims data is influenced by the distribution of spe-

cialists within PRF. The categories are admittedly broad and can overlap. This analysis will be refined as PRF gains a better understanding of the risk profile of its members. The goal is to use claims data to make recommendations to members that will help decrease their risk. ■

Top 10 Claim Areas

Ranking	Area	Comments
1	Surgical Complication	This is understandably the largest category as many PRF members are in surgical specialties. The types of complications are likewise broad and without obvious trends.
2	Dissatisfaction with Outcome	Patients' dissatisfaction with the outcome of plastic surgery can lead to a suit, but often it is the scar resulting from general surgery that prompts a complaint. Interestingly, circumcisions are also a source of dissatisfaction for the parent.
3	Other Complications	Drug reactions, pain, and the need for second procedures will prompt patients to seek redress.
4	Dissatisfaction with Management	Continuing the trend of the unhappy patient are disputes over medical management, bills, and paperwork.
5	Failure to Diagnose	Most of these actions are for breast cancer, other cancers, or pregnancy. Constant vigilance is necessary to prevent these occurrences.
6	Birth Injury	Birth injuries, which include other complications of delivery, while only six percent of all claims, are responsible for 25 percent of the cost of claims, averaging \$250,000 per claim.
7	Perforation	These inadvertent injuries occur at surgery or during diagnostic procedures. Although recognized as potential complications of a procedure and part of the informed consent process, these injuries frequently incur a loss.
8	Delay in Diagnosis	Timely recognition of a condition or complication is critical not only for providing appropriate treatment, but also to avoid the inevitable dissatisfaction of the patient. Acknowledging a complication and being empathetic will help avoid a suit.
9	Patient Death	This unfortunate outcome is difficult for the physician as well as the family. The close personalized support PRF offers its members through the emotionally wrenching time of any suit differentiates PRF from other organizations.
10	Medical Error	False positive tests, wrong site surgery, and alleged unnecessary surgery can lead to a claim. The JCAHO "time out" before initiating surgery serves not only the patient, but the physician as well.

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Newsletter of Physicians Reimbursement Fund, Inc.

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Covering Practice and Risk Management Issues for Physicians

Health Information Technology and the Electronic Medical Record

BY STEVEN BORNSTEIN, MD

You can't go to a medical meeting today without there being a session on the impact of health information technology (HIT) and the electronic medical record (EMR) on improving quality of care and reducing medical errors. With the creation of the Leapfrog Group in 2000, a powerful coalition of 160 companies and organizations that buy healthcare, and the recognition of "Pay for Reporting" and more recently "Pay for Performance," it is obvious that systems that can accurately capture standardized data about organizations and individual providers are needed. Like it or not, computers have become a necessary reality in the practice of medicine in the 21st Century.

So what do computers actually do in the healthcare setting and how can they improve quality outcomes and reduce the risk of errors? The EMR can be divided into several functional areas:

- ▶ They can embed expert knowledge at the point in the care process when decisions are made – so-called "decision support."
- ▶ They can display information that is sorted or filtered and can make the "foraging for information," which can take about 30 percent of a clinician's time, much more efficient.
- ▶ They can make use of standardized tools for documentation and computerized order entry, making possible best practice guidelines and more comprehensive documentation.
- ▶ They can report information in a standardized way so that data can be compared across organizations and down to the provider level as requested by regulators and purchasers.

- ▶ More recently, they foster the exchange and communication of information to the patient, using online "patient homepage" secure internet sites. That enables lab or imaging results to display on the patient's personal computer as well as secure messaging with the healthcare provider as an alternative to office and telephone encounters.

Let's take a look at each of these areas in relation to the EMR:

DECISION SUPPORT

This usually takes the form of an alert or a reminder specific to a patient using data in the system and rules (algorithms) that provide evidence-based suggestions. Figure 1 on the following page is an example of a best practice alert for a diabetic patient suggesting medication interventions. In addition to the suggested action, for the alert to be effective, it needs to make it easy to do the "right thing." In the example from Epic's EpicCare® Electronic Medical

Record in use at Kaiser Permanente, a "SmartSet" to order the appropriate lab and encounter code for diagnosis/order association is offered with a single click. Time efficiency, appropriateness of

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Inside PRF News

Health Information Technology and the Electronic Medical Record

A look at what computers do in the healthcare setting and how they can improve quality outcomes and reduce the risk of errors.

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PRF Analysis Shows Top 10 Claims Areas

Eighty percent of PRF's most costly claims were in ten areas, as this article shows.

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Health Information Technology and the Electronic Medical Record (continued from page 1)

the alert for the specific patient, and reducing the number of alerts to those that support core measures of quality and patient safety are key to avoiding “alert fatigue,”

Group has made use of computerized drug ordering one of its main measures of hospital quality with a particular focus on risk management, medication errors due to

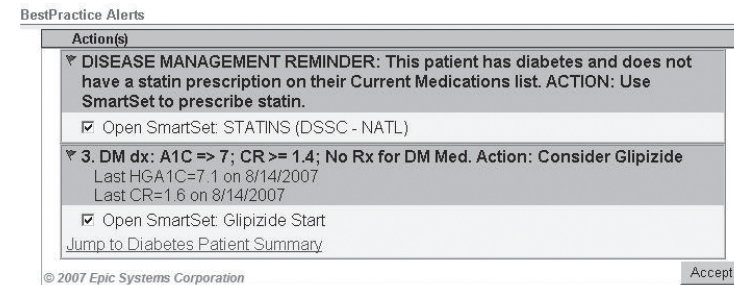


Figure 1.

which can undo the best intentions.

Decision support can also take the form of expert knowledge related to a particular condition or order, with an abstract or more complete citation offered in the form of a web link to a knowledge base. As illustrated in Figure 2 below, referral guidelines, recommended clinical practice guidelines, or pharmacy information (such as drug/drug interaction appearing when ordering the interacting drugs) are typically displayed in this fashion.

The result of such real-time decision support is to decrease medical errors and support evidence-based care. The Leapfrog

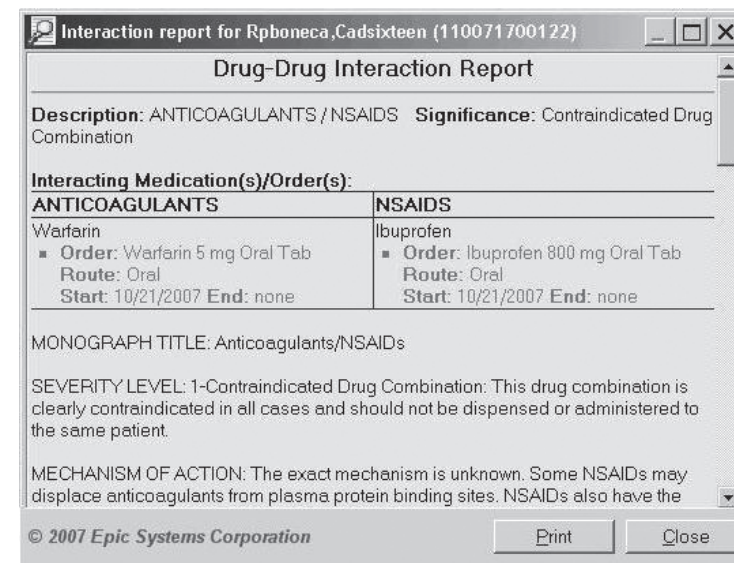


Figure 2.

FINDING INFORMATION

Surveys have reported up to 30 percent of a clinician’s time is spent searching for information in the care of a patient. In a paper chart, the information is often hidden under volumes of pages of paper, and, once found, is often difficult to read. The absence of critical information results in decisions that are error-prone and is a cause of wasteful duplicate testing. Physicians’ illegible handwriting is legendary, and we have all seen the abbreviations and non-standard terminology that make paper charting difficult to understand.

drug/drug interactions, prescribing errors such as allergic reactions and disease drug interactions.

Although some have questioned the effectiveness of these computerized systems, most do feel that when well designed an EMR can reduce or prevent many medication errors of prescribing.

Although some have questioned the effectiveness of these computerized systems¹, most do feel that when well designed an EMR can reduce or prevent many medication errors of prescribing.²

Computers can sort and filter information and organize it in a way that makes the retrieval time efficient. Once found, a computerized note is always legible. In addition, the concept of the “longitudinal patient record” (the information that endures over time and individual encounters), including such areas as the problem list, the medication lists, allergies, and alerts such as drug seeking behavior or communication impairment, becomes easier to maintain and manage in the EMR. This is especially true if the record is shared across several clinicians in the care of chronic medical conditions.

The electronic in-basket is a tool to assure that results are delivered from all laboratory, cardiac, and imaging studies that are ordered. This tool is critical to avoid risks associated with the inadequate

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follow up of important results. Electronic in-baskets are capable of tracking results that are not completed in the expected timeframe or orders that are duplicate, for example, as illustrated in Figure 3 below. They also make it possible to easily interpret results by making trends readily visible.

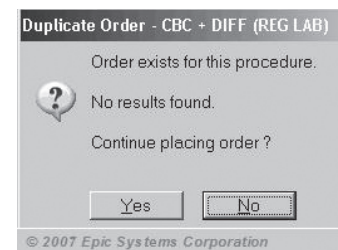


Figure 3.

In short, the EMR makes the longitudinal record of a patient easier to share and maintain and the vertical record (the specific encounter record) easier to find and review. All this leads to improved care and more information at the point of decision, reducing the chance of error.

REPORTING STANDARDIZED DATA

Reporting standardized data has become critical as we move to the era of pay for performance.³ With increased reliance on standardized data sets related to chronic disease, patient satisfaction measures, patient safety measures, and benchmarking of quality standards, computers will become increasingly essential to collect and report on such data. The broad availability of such quality data will also foster population and care management programs that improve outcomes and stress prevention. HEDIS goals and specific disease management goals for chronic conditions require a standardized “lexicon” or language to measure outcomes and define like populations. Such standardized language and linking medical concepts to the historically colorful terminology of physicians will be essential to interpret the

data in a way the Centers for Medicare and Medicaid Services (CMS) and regulators can understand and accept.

INFORMATION SHARING

The Internet and secure communication between patients and care providers has allowed sharing of information which only a few years ago seemed impossible. As patients and clinicians see the benefits of communicating via online messaging, many organizations are embracing the so called “my patient’s online chart” function available in the modern EMR. Communicating via online messaging avoids the “telephone tag” inefficiency inherent in telephone communication by allowing asynchronous messaging in a secure way. The release of lab and imaging information with links to knowledge-base information to explain the results is a very powerful and efficient way to assure that results are communicated and appropriate follow up actions are taken. Widespread

change in the paradigm from the office encounter to “virtual care.”

SUMMARY

In summary, when well designed and implemented, the EMR is a powerful tool to improve quality outcomes and reduce risks of common medical errors. As purchasers and regulators demand “Pay for Performance” measures, the standardized data set reporting that can compare across organizations and individual providers within an organization will necessitate computerized charting and coding with a standardized lexicon. Decision support tools and better availability of legible information across care venues in chronic conditions will allow physicians to improve care, measure outcomes, and reduce risks. The “safety net” of an electronic in-basket reduces the possibility of results not being reviewed in a timely manner or inadequate follow up of important results, especially in high-risk conditions. The newest feature of the EMR, the online patient chart, has

As patients and clinicians see the benefits of communicating via online messaging, many organizations are embracing the so called “my patient’s online chart” function available in the modern EMR.

acceptance will depend on insurance carriers understanding and appropriately reimbursing for such online services. Just as the ATM has become commonplace within the banking industry, the EMR will gain acceptance within the medical industry. This will happen when physicians understand how the reporting of results can be improved and when physicians and patients both learn how the EMR makes communication more efficient and begin to trust the security of the infrastructure. Reimbursement obstacles will need to be addressed as more and more patients and clinicians insist on embracing this

tremendous potential to make patient/physician communication more efficient. As the paradigm of “virtual care” is embraced by patients and clinicians, insurance carriers will need to appropriately reimburse for care services provided outside the office encounter. When this happens, the EMR will become as basic to 21st century healthcare as was the stethoscope to healthcare in the 20th century. ■

Steven Bornstein, MD, is Medical Director of HealthConnect Electronic Medical Record for Kaiser Permanente Northern California Region.

All figures are used by permission of Epic Systems Corporation, Madison, Wisconsin and Kaiser Permanente HealthConnect electronic medical record.

Notes

- ¹ Drug-error risk at hospitals tied to computers. Scott Allen, Boston Globe Staff, March 9, 2005.
- ² Carpenter, James D. Gorman, Paul N. Division of Medical Informatics and Outcomes Research, Oregon Health & Science University, Portland, OR, USA. Using medication list—problem list mismatches as markers of potential error, Proceedings / AMIA . . . Annual Symposium. :106-10, 2002.
- ³ Pay for performance—neither necessary nor sufficient for quality improvement, yet vital for success. Journal for Healthcare Quality. 29(4):4-5, 11, 2007 Jul-Aug, J Healthc Qual. 29(4):4-5, 11, 2007 Jul-Aug.