

# OMIC DIGEST

Ophthalmic Risk Management Digest

## Assuring Safe Passage Through the Healthcare System

By Anne M. Menke, RN, PhD  
OMIC Risk Manager

**D**uring our recent OMIC Forum on "Shared Care" at the AAO annual meeting, Dr. Steven Brown presented the following case involving four competent, experienced physicians. A primary care physician (PCP) referred an elderly gentleman to a comprehensive ophthalmologist (CO) for evaluation of a grey spot in his eye. After diagnosing a melanoma, the CO referred the patient to a retina specialist for confirmation and treatment options. The retina specialist offered the patient a choice between radiation and enucleation, and reported back that the patient chose enucleation. The CO then referred the patient to an oculoplastic surgeon for the procedure, which was completed two weeks after the initial ophthalmological evaluation. So far, the patient had received timely, effective, well-coordinated care. Nonetheless, when the patient died from metastatic disease that was diagnosed by his PCP eight months after his eye was removed, his family requested the medical records and concluded that the care was negligent. They reached their conclusion after finding a report from the retina specialist to the CO, advising him of the need for tests to monitor for metastasis. The family proceeded to sue the PCP, CO, and oculoplastic surgeon, alleging failure to follow-up and coordinate care. Investigation revealed that all three physicians knew the patient was at risk for metastatic disease, and knew which tests to order to monitor for it. Yet no one took the responsibility to clarify who was in charge, and none of them ordered the necessary tests. The oculoplastic surgeon testified that he had explained the need for follow-up to the patient but did not provide his recommendations in writing or document them in his record. No doubt the patient was not able to truly hear these care instructions while facing a new diagnosis of cancer and recovering from an enucleation.

### Patient "Hand Off" A Critical Moment In Care

The Joint Commission (TJC) receives regular reports of medical errors that occur at the hospitals, ambulatory surgery centers, and other healthcare organizations that it accredits. By analyzing the problems, TJC hopes to understand not only which errors occur but more importantly what causes them. What TJC determined echoes the findings of the OMIC case. The top factor contributing to medical error was not lack of knowledge or technical skills

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## MESSAGE FROM THE CHAIRMAN



When the Centers for Medicare & Medicaid Services (CMS) announced earlier this year that Medicare reimbursement for Bevacizumab (Avastin®) would decrease from \$35 to \$7 a dose, it sent shock waves through the retina community. Although ophthalmologists, like other physicians, have grown accustomed to lower fee

reimbursements across the board, this particular action posed such a significant threat to our ability to provide care to our patients that it was imperative it be reversed.

Major ophthalmic societies, including the American Academy of Ophthalmology, the American Society of Retina Specialists, the Macula Society, and the Retina Society, united in a coordinated effort to convince Medicare to reverse the decision. Key members of OMIC's Board, including Dr. David W. Parke II, CEO of the American Academy of Ophthalmology, and Dr. George A. Williams, a leading retina surgeon at William Beaumont Hospital in Royal Oak, MI, contacted Medicare officials to help educate those involved of the unintended consequences of such a fee decrease. Ironically, these included increased cost to Medicare if doctors suddenly switched to

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# Eye on OMIC

## OMIC

The Ophthalmic Risk Management Digest is published quarterly by the Ophthalmic Mutual Insurance Company, a Risk Retention Group sponsored by the American Academy of Ophthalmology, for OMIC insureds and others affiliated with OMIC.

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## OMIC Expands Regulatory Protection for Policyholders

Ten years ago, OMIC was among the first malpractice carriers in the United States to cover policyholders for regulatory exposures, such as fraud and abuse “billing errors” allegations by Medicare and commercial payers. Since then, more than 250 claims and incidents have been reported to OMIC for these and other regulatory proceedings.

As a benefit of membership, OMIC provides \$35,000 in Broad Regulatory Protection (BRPP) coverage as part of your professional liability policy (see section VII.B. of your policy for more information). This expanded coverage, effective January 1, 2010, applies to fraud and abuse claims related to billing errors, HIPAA privacy proceedings, and violations of Emergency Medical Treatment and Active Labor Act (EMTALA) and STARK Act regulations, including reimbursement of legal expenses, fines, and penalties (where allowed by law). This policy also covers legal expense reimbursement for alleged violations of DEA and covered licensing proceedings. A \$10,000 sublimit is now available to pay patient notification costs due to Red Flag rules violations (see section VII.C. of your policy for more information).

OMIC has arranged several purchasing options for additional coverage to supplement the \$35,000 Broad Regulatory Protection OMIC has provided to you. Excess limits of \$40,000 and \$90,000 may be purchased as a standard BRPP upgrade; limits of \$250,000, \$500,000, and \$1 million are available as a BRPP Plus upgrade. (This excess coverage is provided under a separate policy issued by NAS/Lloyds of London underwriters and is in addition to OMIC’s \$35,000 limit included as part of your professional liability policy.)

Those policyholders who have already purchased excess BRPP coverage will automatically be given renewal terms for the 2010 expanded policy approximately 60 days prior to your current BRPP policy expiration, including the new liability limits now available through Lloyds of London underwriters.

A copy of OMIC’s professional liability policy can be downloaded from the Members Area of OMIC’s website at [www.omic.com](http://www.omic.com). You will need your insured name and risk number to log in. This information is located on your policy declarations page. Applications for increased BRPP or BRPP Plus limits are also available online.

Call your OMIC underwriter or the NAS/Lloyds BRPP administrator at NAS Insurance Services, Dana Pollard at (818) 808-4468, for assistance.

## Message from the Chairman

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Lucentis and millions of elderly patients were unable to afford the copayment for this much more expensive drug.

This is where OMIC’s risk management team excelled in communicating with ophthalmologists about this issue. OMIC’s 2007 recommendations for intravenous Avastin warned practitioners that the drug must be prepared by a licensed and trained professional in a compounding or hospital pharmacy to avoid the liability risks associated with off-label ophthalmic use.

Coming from the nation’s largest insurer of ophthalmologists and retinal subspecialists and disseminated via OMIC.com, one of the most frequently visited ophthalmic websites in the U.S., OMIC’s recommendations were influential. In concert with other actions initiated by the AAO and the three retina societies, OMIC provided background information that helped in the effort to persuade CMS to reverse its

decision. In November, CMS directed practitioners to “return to their previous reporting practice for small intraocular doses of Bevacizumab (Avastin®) furnished prior to October 1, 2009.”

Dr. William L. Rich, AAO’s Medical Director for Health Policy, expressed it best, “The AAO, all three retinal societies, Congress, and our patients are all very thankful for this reversal. It benefits patients, doctors, and taxpayers.”

I am proud of OMIC’s role in the success of this collective endeavor. When we work together, we can achieve significant advancements for the ophthalmic community and our patients. We can reduce our risks, minimize threats to our livelihood, and protect the quality of care for our patients. Victories such as this are not just “feel good” stories about ophthalmologists working together to effect change, but also examples of the strategic and financial advantages we have gained by creating our own ophthalmic malpractice carrier.

**Richard L. Abbott, MD**  
OMIC Chairman of the Board



## Changes to Your OMIC Policy for 2010

By Kimberly Wynkoop  
OMIC Legal Counsel

Insureds will be receiving their new OMIC Professional and Limited Office Premises Liability Insurance Policy in the mail with their 2010 renewal materials. Although these are minor changes to the policy, we encourage Insureds to be aware of the content and meaning of their insurance policies. Therefore, we are providing an outline of the changes below, and encourage Insureds to contact their underwriter if they have questions. Any benefits added to the policy take effect as of January 1, 2010, unless earlier as otherwise noted below. Any changes that may restrict coverage do not take effect until the Insured's policy renewal date.

OMIC has simplified the vicarious liability language in Section II. Coverage Agreement A: Professional Liability Coverage for Ophthalmologists. The policy now states that the Insured ophthalmologist is covered for direct patient treatment provided by the Insured or "any person acting under the supervision, direction, or control of the Insured at the time of the professional services incident, so long as that person was acting within the scope of his or her licensure, training, and professional liability insurance coverage, if applicable." It no longer differentiates between employees, former employees, and others for whom the Insured may be responsible, and does not require that the person be acting within the scope of his or her "employment by and for the direct benefit of the Insured." However, for an employee to be covered directly, he or she must still be acting within the scope of his or her employment by and for the direct benefit of the insured.

OMIC has now incorporated the coverage that was previously provided to Insureds under a separate BRPP policy into the professional liability policy

itself, in Section VII. Additional Benefits, B. Broad Regulatory Protection. The limit for regulatory proceedings under this additional benefit has been increased from \$25,000 to \$35,000 per regulatory proceeding. The section also makes clear that in the unlikely case that coverage falls under both regulatory and disciplinary proceeding coverage (Additional Benefit VII.A.), only one limit, not both, applies. A new benefit, Patient Notification Costs Coverage, with a \$10,000 sublimit of the \$35,000 provided in Section VII.B., was added as Section VII.C. This benefit provides reimbursement to Insureds for their reasonable and necessary public relations, postage, and related advertising expenses incurred in notifying patients of any violation of federal, state, or local statutes or regulations associated with the control and use of personally identifiable financial or medical information, including HIPAA. In Section VIII.12. Other Insurance, subsection e., the policy also clarifies that these additional benefits are excess of any other insurance, unless another policy is purchased to specifically apply in excess of these benefits. For instance, OMIC sponsors additional insurance programs offered through NAS Insurance Services, which includes an excess policy providing higher BRPP limits of liability.

At its February 7, 2009, meeting, the OMIC Board of Directors amended the policy's Consent to Settle clause, Section VIII.11. The Board removed the provision (sometimes called a "hammer clause") that lowered the Insured's limit of liability for the applicable claim if he or she refused to consent to settle the claim on OMIC's good faith recommendation. This change is reflected in the 2010 policy wording.

A new subsection 26. Compliance with Applicable Law, was added to Section VIII, General Conditions, Rules, and Duties, which states that all policy terms shall be construed and administered in a manner consistent with applicable federal and state law, and that, if any provision of the policy is determined to be invalid, all remaining provisions are still binding.

Several changes were made to the Coverage Classification endorsements. As the Board approved May 30, 2009, sub-tenons injections were reclassified from Surgery Class 1 to Surgery Class 2. At that time, the Board also modified the term non-surgical ophthalmology, which includes diagnosis and non-surgical treatment of diseases, to exclude the screening for and treating of retinopathy of prematurity. This effectively requires Insureds to be in Coverage Class 3 (full surgery) to perform ROP screening and treatment. The Board reclassified ROP services for several reasons, including the significant potential for high damages when claims arise. At its September 26, 2009, meeting, the Board broadened and clarified the types of oculoplastic and cosmetic procedures covered under Surgery Class 2. This section was reworded to include descriptions such as "rejuvenation/tightening using non-invasive, non-ablative techniques," "blue light acne treatment (with or without use of photodynamic therapy)," and "non-invasive cellulite reduction."

Two state-specific automatically applied endorsements were added to the policy. A Florida endorsement was added to comply with Florida claims settlement laws, which, unlike most state insurance laws, are generally not preempted by the Liability Risk Retention Act, a federal law that governs risk retention groups, such as OMIC. The endorsement revises Section VIII.9. of the policy; it requires Florida Insureds to cooperate in the claim review process prescribed by Florida law. It also revises Section VIII.11., giving OMIC the right to settle claims within the Insured's policy limits without the Insured's permission, if done in good faith and in the Insured's best interest, as Florida law prescribes.

A Pennsylvania endorsement was added for all Insureds who participate in Pennsylvania's Medical Care Availability and Reduction of Error Fund (Mcare). As required by Mcare, the endorsement deletes coverage for locum tenens and MSOs and changes how liability limits are shared.

# Assuring Safe Passage Through the Healthcare System

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or inexperience. Rather, it was problematic communication: the information conveyed during care was incomplete, inaccurate, and/or misinterpreted. Ineffective communication occurred in 70% of "sentinel events," a term TJC uses for incidents that have the most serious outcomes. Just as with the OMIC case, fully half of the time, the harmful communication breakdown occurred during a "patient hand off."<sup>1</sup>

Patient safety experts, aware of the dangers of the hand off, have focused attention on ways to ensure communication and coordination of care during the moments when patients transition from one provider, facility, or unit to another. "Lost in Transition: Challenges and Opportunities for Improving the Quality of Care" points to our fragmented American healthcare system as the cause: decreasing numbers of primary care physicians, increasing numbers of patients with more than one disease who require diagnostic tests and specialists, and a payment system that does not reimburse physicians for the time it takes to communicate with one another and coordinate care.<sup>2</sup>

A literature review of care transitions found that patients referred to a specialist arrived 49% of the time with no information about the patient. The consultants apparently responded in kind, as the referring physicians complained that even four weeks after the consultation, 25% had not received a report back. PCPs said they were not notified that patients had been hospitalized and rarely received discharge summaries. The few that came were inadequate for directing care. Patients received even less information. Those sent for tests said that 17% of the time the physician had not received the results by the time of the office visit scheduled to discuss them. More than 75% of physicians report not informing patients when test results are normal, and 33% do

not even disclose abnormal results. The author concluded that, "Care among multiple providers must be coordinated to avoid wasteful duplication of diagnostic testing, perilous polypharmacy, and confusion about conflicting care plans."<sup>3</sup>

To help ophthalmologists coordinate care and follow up on referrals, test results, and appointments, OMIC developed a tracking system, which is discussed in the **Hotline** article and presented in detail in our document, "Noncompliance: A Frequent Prelude to Malpractice Lawsuits," available in the risk management recommendations section at [www.omic.com](http://www.omic.com). A tracking system is only effective, however, if all physicians involved in the care of a patient are clear on who is in charge of ordering, interpreting, communicating, and acting upon the results of tests and consultations. As the OMIC case demonstrates, sending a letter with the proper recommendations does not lead to safe care if the message is not received and acknowledged. A more active process is required. Several new regulations imposed on healthcare facilities have been adopted to force physicians, nurses, and other caregivers to better coordinate care and hand off patients. The first is medication reconciliation, the second is standardized hand-off discussions; each will be addressed in turn.

## Reducing Errors from Medication Changes

OMIC claims experience and the studies discussed so far show that patients and providers alike appear to be inadequately prepared for their role in the next phase of care. This is particularly true with changes to medications, which occur regularly when patients undergo diagnostic/surgical procedures, are diagnosed with new conditions, or are hospitalized. Too many times, neither the patient nor the prescribing physician has accurate and complete information about the patient's current medication regime. The stage is thus set for errors and adverse drug

events that result in patient harm, hospitalization, increased costs, and allegations of medical malpractice.

Take anticoagulants, for example, which are among the top three classes of drugs involved in medication errors. Ophthalmologists who are planning procedures with a high risk of bleeding, such as blepharoplasty, routinely inquire about prescription and over-the-counter drugs that influence the clotting cascade, and make changes to the drug regimen preoperatively. OMIC claims studies have shown, however, that patients misremember which medications they are taking, misrepresent—often when faced with financial problems—when they last had clotting studies done by their primary care physician, or do not think to report recent cardiac procedures, such as the placement of stents. Failure to confirm dosages, test results, and the intended change in medication with PCPs and cardiologists, failure to confirm that a patient has indeed stopped medications as directed, and failure to provide comprehensible, written instructions on how and when to restart medications have all led to malpractice lawsuits. Adverse medication events such as these indicate the need for an explicit process of "medication reconciliation" at key transition moments, such as a new diagnosis, admission for surgery, or discharge from a healthcare facility. This step is now a "National Patient Safety Goal" that facilities must meet in order to maintain accreditation by organizations such as TJC and AAAHC.<sup>4</sup> And while time consuming, the process works: studies show that medication reconciliation decreases medication errors by 70% and adverse drug events by 15%.<sup>2</sup>

## Tools to Improve the Quality of Hand Offs

One study of hand offs looked at the accuracy of information exchanged by nurses during shift change. Twelve fictitious patients were created, and nurses passed on information during five consecutive hand overs.

Oral communication resulted in the loss of all data. Note taking during hand off reduced data loss to 31%. It was only when a standardized form was combined with oral exchange of information that data loss was minimal.<sup>5</sup> Studies such as this convinced many organizations, including the Institute of Medicine, the Department of Defense Patient Safety Program (DOD), Kaiser Permanente, and AORN (Association of periOperative Registered Nurses) to produce tools to better structure patient hand offs. These teams learned that standardized hand offs shifted the focus from the people involved in the exchange (often hierarchical) to the patient, and led to common expectations about what was going to be communicated, how the communication would be structured, and the required elements. Most importantly, the process requires two-way conversation in which critical information is verified and clear responsibility for ongoing care is established.

The toolkit jointly developed by the DOD and AORN is particularly useful to ophthalmologists as it focuses on

## TALK TO ME IN SBAR

### SITUATION

Why are you calling this physician?  
Identify yourself, unit, patient, etc.  
Briefly state the problem: what, when, severity

### BACKGROUND

Information related to the situation  
Admission diagnosis and date  
Most recent vital signs  
List of current medications, allergies, IV fluids, test results  
Lab results: date and time done, comparison to previous results  
Other pertinent clinical information

### ASSESSMENT

What is your assessment of the situation you are calling about?

### RECOMMENDATIONS

What do you want from the physician?  
Test or medication order?  
Patient needs to be seen now?  
Order change?

## I PASS THE BATON

<b>I</b>	Introduction	Introduce yourself and your role/job (include patient)
<b>P</b>	Patient	Name, identifiers, age, sex, location
<b>A</b>	Assessment	Presenting chief complaint, vital signs, symptoms, diagnosis
<b>S</b>	Situation	Current status, medications, circumstances, including code status, level of (un)certainity, recent changes, response to treatment
<b>S</b>	SAFETY Concerns	Critical lab values/reports, socioeconomic factors, allergies, alerts (falls, isolation, etc.)
<b>THE</b>		
<b>B</b>	Background	Comorbidities, previous episodes, past/home medications, family history
<b>A</b>	Actions	What actions were taken or are required AND provide brief rationale
<b>T</b>	Timing	Level of urgency and explicit timing, prioritization of actions
<b>O</b>	Ownership	Who is responsible (nurse/doctor/team) including patient/family responsibilities
<b>N</b>	Next	What will happen next? Anticipated changes? PLAN? Contingency plans?

team building and was developed specifically for perioperative care.<sup>6</sup> It provides information on several standardized hand-off formats (see **TALK TO ME IN SBAR** and **I PASS the BATON**). Ophthalmologists would be well advised to become familiar with these hand-off processes, now that the Joint Commission, in National Patient Safety Goal 2E, requires facilities to implement a standardized approach to hand offs. TJC has clarified its expectations: hand offs must be interactive, allowing for participants to ask and answer questions; they must include accurate, current information; interruptions during hand offs should be minimized; they must include a process for verification of the received information, including read back or repeat back if needed; and other necessary patient information should be available for review.<sup>7</sup> It will no doubt take time to hone the hand-off process, but the effort will clearly result in safer care and less liability.

1. JCAHO. "Improving Hand-off Communications: Meeting National Patient Safety Goal 2E." *Joint Perspectives on Patient Safety* 2006; 6(8): 9-15.
2. Coleman EA and Berenson RA. "Lost in Transition: Challenges and Opportunities for Improving the Quality of Care." *Ann Intern Med* 2004; 140: 533-536.
3. Bodenheimer, Thomas. "Coordinating Care—A Perilous Journey Through The Healthcare System." *New England Journal of Medicine* 2008; 358: 10.
4. Several resources provide medication reconciliation tools. The Agency for Healthcare Research and Quality has a primer available at <http://www.psnnet.ahrq.gov/primer.aspx?primerID=1>. The Institute for Healthcare Improvement has a tool to help review medical records to catch medication errors and develop an effective reconciliation process; this tool is available at <http://www.ihl.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/Medication+Reconciliation+Review.htm>.
5. Pothier D, Monteiro P, Mooktiar M, Shaw A. "Pilot study to show the loss of important data in nursing handover." *British Journal of Nursing* 2005; v.14, n.20.
6. The toolkit, which includes slide presentations, sample tools, and forms developed for perioperative use, is available at <http://www.aorn.org/PracticeResources/ToolKits/PatientHand-offToolkit/>.
7. The Joint Commission's National Patient Safety Goal on hand-off communication can be found at [http://www.jointcommission.org/AccreditationPrograms/LongTermCare/Standards/09\\_FAQs/NPSG/Communication/NPSG.02.05.01/hand\\_off\\_communications.htm](http://www.jointcommission.org/AccreditationPrograms/LongTermCare/Standards/09_FAQs/NPSG/Communication/NPSG.02.05.01/hand_off_communications.htm). Accessed Dec. 1, 2009.



# Closed Claim Study

## Preoperative, Intraoperative, and Postoperative Deficiencies in Care of LASIK Patient

By Ryan Bucsi, OMIC Senior Litigation Analyst

### ALLEGATION

Failure to examine patient prior to surgery, lack of adequate informed consent, poor surgical technique, and lack of follow-up postoperatively.

### DISPOSITION

Case settled for \$450,000.

### Case Summary

This patient was examined at a laser center by two technicians who informed him that he was a good candidate for LASIK. On the day of surgery, the patient declared that he was too anxious to have the procedure, but he was reassured by an optometrist and decided to proceed. The OMIC insured, whose first contact with this patient was just prior to surgery, claimed that the patient moved his head during surgery causing a thin flap with a central hole OD. The following day, the patient was evaluated but not by the insured. Two days postoperatively, the insured had his second and last contact with this patient when he performed a “refloat” procedure. The patient then sought care at another facility where he was diagnosed with decreased vision due to irregular astigmatism, corneal scarring, and some missing flap OD. The patient corrected to 20/20 OD with a contact lens, but he was unable to tolerate the contact lens. A corneal specialist was consulted and a corneal transplant was recommended, however the patient was unwilling to have the transplant and was left with extreme loss of vision, double vision, and blurriness OD.

### Analysis

It was the plaintiff expert’s opinion that the insured was not qualified to perform LASIK as he had only been doing so for two months prior to this incident. This expert testified that the patient should have had PRK due to a corneal thickness of less than 500 microns in both eyes. From the operative note, the plaintiff expert testified that the LASIK surgery was negligently performed because the insured pulled up on the microkeratome, therefore losing suction resulting in a buttonhole complication. Furthermore, the expert said it was inappropriate to remove any part of the flap as the insured did during the refloat procedure.

In addition to these criticisms, several key facts became evident during discovery that led to a decision to settle. There was no documentation in the surgery center records regarding who diagnosed the patient as a LASIK candidate, and the insured did not actually see the patient

until the day of surgery. The insured claimed that he wrote a very detailed chart note about the patient jerking his head during the surgery when he examined the patient on postoperative day two. However, this note was never located and members of the surgery center maintained that no such note was written. Furthermore, the patient’s wife had observed the original surgery and testified that her husband did not move his head suddenly during the procedure, which was consistent with the patient’s testimony. The patient and his wife also testified that the insured told them postoperatively that he had pulled up on the microkeratome, lost suction, and a thin flap was created.

The insured was subsequently interviewed on local television where he expressed his displeasure with the microkeratome that was being used and claimed he was promised a different device, but the surgery center never delivered on this promise. The plaintiff used this interview to argue that the insured knew the surgery center was providing substandard care and should have protected the patient by fully informing him of known problems at the center. This interview and the lack of documentation essentially “sealed the deal” as far as settlement was concerned.

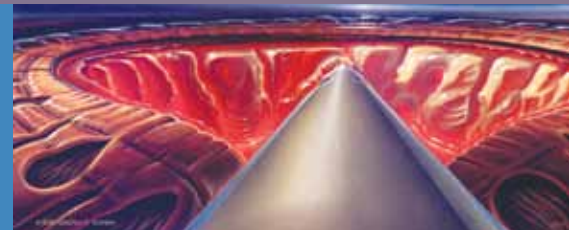
### Risk Management Principles

Incomplete or missing documentation compromises the defense of any medical malpractice case, but there were other problems with this patient’s care. First, the surgery center employees overrepresented the patient as a suitable candidate for LASIK. Technicians cannot determine a patient’s surgical candidacy, only the surgeon can. If a patient will not be examined by the surgeon until the day of surgery, other steps should be taken to determine if the planned procedure is appropriate for the patient.

Second, the patient’s concerns about surgery were never relayed to the insured by the optometrist. OMIC expects the surgeon to personally obtain informed consent and to personally address any concerns the patient has. If the surgeon is meeting a patient for the first time on the day of surgery, the consent document must be mailed to the patient beforehand (see OMIC’s refractive surgery guidelines at [www.omic.com](http://www.omic.com)).

Finally, during the course of active litigation, it is never a good idea to talk with anyone, especially the media, about an open and pending medical malpractice lawsuit.

# Risk Management Hotline



## Tracking Referrals and Test Results

By Anne M. Menke, RN, PhD  
OMIC Risk Manager

**T**he OMIC claim discussed in this issue's lead article involved a patient who was never informed of the need for tests. Other claims result from patients who do not follow instructions to see consultants or undergo diagnostic testing. Both scenarios can lead to patient harm and increased liability risk.

**Q** Whose responsibility is it to order and review tests and disclose the results to the patient?

**A** This question needs to be explicitly addressed and answered for each patient when more than one physician is involved. If you want to have the results of tests in hand when you first examine the patient, consider developing a form to send to the referring physician. Ask the physician to state the reason and urgency of the appointment being requested and to provide the contact and medical information you need to evaluate the patient. Indicate the tests that should be completed before you will see the patient. Clearly state who will order the tests and verify that the patient has completed them: "Please send the patient for the following tests and contact my office when you have received the test results." In some situations, you may not know which tests need to be done until you examine the patient. Tests you choose after examination would normally be tracked by your office.

**Q** Do you have a system you can recommend to track referrals and tests?

**A** Yes. When you determine that a patient needs a consultation with a specialist or a diagnostic test, disclose it to the patient, explain the reason for the order, and document your discussion and order. Ask the patient

to schedule a follow-up visit or telephone consultation with you before leaving the office so you can review the results and revise the care plan. Next, instruct your staff to enter the information into a tracking system (see sample below). The system can be a follow-up tracking form, logbook, card file, or spreadsheet on the computer. When the report arrives, instruct staff to attach it to the patient's file and place on your desk for your review. Date and sign the report, indicate any follow-up needed, and place in the medical record. Disclose the results to the patient and document the discussion. Communicate and document the new treatment plan. Update the tracking form.

**Q** What steps do I need to take to ensure that I get the report?

**A** There are two ways to ensure that patients obtain the requested tests/consultations and you receive a report. First, assign to a reliable staff member the responsibility of reviewing the tracking system on a regular basis. Second, ask staff as part of preparing records for the next day's patients to review each file to see if any report or result is expected. If the report is not received in the usual time, ask staff to call for results. If you learn that the patient did not present for the test or consultation, ask staff to contact the patient to learn why. Be sure to question patients in a non-judgmental manner: "We called to get the results of your MRI and were told that you had cancelled it. Was there some kind of problem? Could you tell me why you didn't have this done?"

**Q** What if patients refuse the recommended care?

**A** Clarify why the patient is not complying with treatment recommendations. Possible reasons for not scheduling tests or procedures may include financial difficulties, HMO authorization problems, transportation difficulties, child care problems, confusion about the disease or the need for treatment, or fear of the significance of the results of the test, procedure, or consultation. Next, educate the patient about the disease process, treatment recommendations, and consequences of non-compliance. Target the education to the reasons for non-compliance. When possible, identify social service resources that may help. For example, some pharmaceutical companies provide free or reduced-cost medications. Be familiar with the enrollment criteria and process for state and federal assistance, and of transportation services for patients. If treatment is not authorized by the patient's HMO, act as a patient advocate and appeal the decision. Verify that the patient understands the points being made by asking the patient to explain them back to you in his or her own words. Give written materials whenever possible, and use visual teaching aids, such as videos, charts, diagrams, and models of the eye. If your efforts to educate and clarify the need for treatment are not effective, you may need to terminate the relationship (see "Noncompliance" and "Termination of the Physician-Patient Relationship" at [www.omic.com](http://www.omic.com)).

SAMPLE PATIENT TRACKING SYSTEM

PATIENT	TEST PROBLEM PROCEDURE REFERRAL	DATE ORDERED	DATE OF RESULTS	FOLLOW-UP NEEDED	DATE COMPLETED
Kim Garcia	To Dr. Allen	10/1	10/7	Call patient: appointment	10/8
Bob Pearce	MRI	10/3	10/20	To Dr. Hall	10/21



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94188-0610



## Calendar of Events

OMIC continues its popular risk management courses in 2010. Upon completion of an OMIC online course, DVD, CD or MP3 recording, or live seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society (indicated by an asterisk) may earn an additional discount by participating in an approved OMIC risk management activity. Courses are listed here and on the OMIC website, [www.omic.com](http://www.omic.com). CME credit is available for some courses. Please go to the AAO website, [www.aao.org](http://www.aao.org), to obtain a CME certificate.

### Upcoming Seminars

#### January

- 8** *Evaluating Competency; Handling Incompetency*  
Connecticut Society of Eye Physicians\*  
Aqua Turf Club, Plantsville; Noon  
Contact Debbie Osborn at (860) 567-3787
- 11** *Evaluating Competency; Handling Incompetency*  
Northern Virginia Academy of Ophthalmology  
Maggiano's at Tyson's Corner, McLean, VA; 6:30 pm  
Contact NVAO at (703) 698-9335
- 12** *Evaluating Competency; Handling Incompetency*  
Washington DC Metropolitan Ophthalmological Society\*  
Location TBA; 6:00 pm  
Contact [info@wdcmos.org](mailto:info@wdcmos.org)
- 23** *Evaluating Competency; Handling Incompetency*  
Ohio Ophthalmological Society\*  
Hilton at Easton, Columbus, OH; 2:40-3:40 pm  
Contact OOS at (614) 527-6799 or [tbaker@ohioeye.org](mailto:tbaker@ohioeye.org)

#### February

- 19-20** *Illinois Claims Experience*  
Illinois Assn of Ophthalmology\*  
Stephens Conference Center, Rosemont, IL; Morning Session  
Contact IAO at (847) 680-1666 or <http://www.IEyeMD.org>
- 26** *Handling Incompetency*  
Utah Ophthalmology Society 31st Annual CME Conference & Expo  
South Towne Expo Center, Sandy, UT; 9:30-10:30 am  
Contact Annette Mahler at (801) 747-3500, ext. 236, or [www.utaheyemeds.org](http://www.utaheyemeds.org)

#### April

- 12** *New Documentation & Communication Strategies for LASIK & Cataract Surgery Informed Consent Process (Session #12-105)*  
American Society of Cataract & Refractive Surgery  
Boston Convention & Exhibition Center, Boston, MA; 8:00-9:30 am  
Contact [www.ascrs.org](http://www.ascrs.org)

- 16** *Evaluating Competency; Handling Incompetency/ROP Claims*  
American Assn for Pediatric Ophthalmology & Strabismus\*  
The Swan, Orlando FL; 2:00-3:30 pm  
Contact [www.aapos.org](http://www.aapos.org)

- 30** *Evaluating Competency; Handling Incompetency*  
Texas Ophthalmological Assn\*  
Fort Worth Convention Center, Fort Worth, TX; Morning Session  
Contact TOA at (512) 370-1504 or [www.txeyenet.org](http://www.txeyenet.org)

OMIC will operate on a dramatically reduced schedule and respond only to urgent matters between Dec. 24 and Jan. 1. If you have an urgent matter and must speak to a staff member during the holidays, please call (800) 562-6642, ext. 609, and leave a message. Staff will check this message line throughout the week and return urgent calls in a timely manner. Non-urgent calls will be returned on Monday, Jan. 4. The OMIC staff wishes you and your family a safe and happy holiday.

Contact Linda Nakamura at (800) 562-6642, ext. 652, or [lnakamura@omic.com](mailto:lnakamura@omic.com) for questions about OMIC's risk management programs, CD/DVD recordings, or online courses.