

OMIC DIGEST

Documentation Issues in Paper & Electronic Records

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

When lawsuits against policyholders are resolved and the claim is closed, OMIC asks insured ophthalmologists about 1) risk management issues that were brought to their attention by the claim and 2) the steps they have since taken to reduce exposure to this type of claim in the future. In our most recent surveys covering the latter half of 2013, fully half of the answers to the first question and a third of the responses to the second were about documentation problems that had impacted the claim. To better understand the precise type of documentation issues that influenced the outcome of recent cases, I reviewed OMIC lawsuits that closed in 2012 and 2013. This article will address the most common deficiencies, in decreasing order of frequency.

Operative report

Not surprising for a surgical specialty, operative reports are carefully scrutinized in ophthalmic surgery lawsuits. In many claims, the operative report failed to mention complications that led to poorer than anticipated outcomes and unhappy patients. The majority of OMIC claims relate to cataract surgery, and the main documentation deficiency in the cataract claims reviewed for this article was the absence of discussion of capsule rupture. This is a known complication and if it is documented, disclosed to the patient, and managed well, the defense attorney would argue that the outcome was a maloccurrence rather than malpractice.

In one such case, a patient alleged persistent glare, halos, corneal edema, and extreme light sensitivity caused

by an irregular iris following cataract surgery. The defense expert reviewing the case explained that he could not determine if the standard of care was met or not based upon the operative report as it did not mention that the surgeon had performed an anterior vitrectomy, removed the entire capsular bag, and somehow injured the iris. The defense expert surmised that the ophthalmologist encountered floppy iris syndrome but noted that the only action documented in the medical record to address it was to administer Atropine. The insured ophthalmologist consented to settle and OMIC paid \$200,000.

Other operative note deficiencies include failing to document an adverse event (see *Closed Claim Study*); operative notes that were pre-dictated but not amended to address complications; lack of any operative note at all (a LASIK surgeon explained that if the surgery had no complications, he did not dictate a report; see the discussion of this case under "Telephone care"); and two operative notes, dictated one day apart, offering different accounts of the surgery (the plaintiff dismissed the case before the reason for the two forms

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Message from the Chair

"It's just words on a piece of paper!" This was the tearful response of my son, then 5, who had "graduated" from kindergarten and expecting a trophy or some other shiny hardware, had instead received an unframed computer-generated "diploma." As he fought back bitter tears of disappointment (and I stifled a chuckle at the pomp of a kindergarten graduation in the first place), I hugged him close and tried to reassure him that some of the

most important things in life are "words on a piece of paper." Whether a birth certificate, medical license, or mortgage note, just about every important life event, achievement, or transaction is formalized with a document.

Words on paper (and increasingly, a computer screen) continue to be the primary method physicians use to record the patient encounter. When things go wrong, when there is a dispute, when answers are needed regarding a clinical outcome, the only reliable information available is what was documented in the medical record. One of the earliest tenets of risk management hammered into us during training is to document thoroughly and

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Coverage for Bilateral Intraocular Refractive Surgery

After careful consideration and analysis of available data regarding the performance of immediately sequential bilateral refractive lens exchange and phakic implant surgery, OMIC has approved coverage for these procedures subject to special conditions for patient selection, informed consent, and surgical protocols. Policyholders performing intraocular refractive surgery require a special coverage endorsement. If you need to add this coverage or verify the current endorsements on your policy, contact your OMIC representative. To review OMIC's required protocols for immediately sequential bilateral refractive lens exchange and phakic implant surgery, visit <http://www.omic.com/policyholder/am-i-covered-for-performing-bilateral-same-day-rle-or-bilateral-same-day-phakic-implant-procedures/>.

When making the decision whether to offer coverage for procedures that could present an increased risk to the company or our insureds,

OMIC examines many factors we believe may affect the defensibility of claims. We collect available peer-reviewed literature that supports the safety and efficacy of the procedure and solicit input from a variety of experts in the specialty regarding standard of care issues and risks, benefits, and alternatives. We also attempt to determine the percentage of ophthalmologists currently performing, or intending to perform, the procedure. Finally, we consult with attorneys regarding potential legal obstacles, including suggested strategies for mitigating exposure to claims or lawsuits.

Because premiums are directly related to the shared claims experience of our insureds, continued review and management of identified risks is essential to maintaining OMIC's industry-leading operating performance. Our mission is to provide comprehensive coverage for the full scope of ophthalmic practice while maintaining competitive rates and above average dividend returns.

Message from the Chair

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maintain the integrity of the medical record. "If it's not in the record, it wasn't done," is a familiar plaintiff attorney refrain.

Failure to document, lost charts, medication errors, illegible entries, and altered records are examples of documentation deficiencies that have torpedoed an otherwise defensible OMIC malpractice claim. The migration of medical documentation to the electronic record is the solution, we are told, to most of what ails the paper record. Perhaps, but not necessarily. On the plus side, lost charts, illegible handwriting, and record alteration should be a thing of the past. On the minus side, with the click of a mouse, one can copy, paste, and propagate redundant, repetitive, and sometimes inaccurate data. In this issue of the *Digest*, we explore the state of medical record documentation to better harness the good parts of the electronic platform while avoiding its pitfalls.

Speaking of words on paper, we are excited about a project OMIC has entered into with the AAO's Hoskins Center for Quality Eye Care. We are translating each of the consent forms on the

OMIC website into Spanish. This will make our internationally recognized library of ophthalmic consent forms available to a broader audience.

Our insureds spoke; we listened. While already permitting immediate sequential bilateral cataract extraction, OMIC has modified its underwriting requirements to allow immediate sequential bilateral intraocular refractive surgery. With appropriate guidelines and proper informed consent, insureds may now offer this option to patients seeking same-day bilateral refractive lens extraction.

Finally, every five years, our financial statements and overall corporate governance are reviewed by auditors from our domicile state of Vermont. I am happy to report that OMIC received the top rating on its internal financials and controls and was placed in the top compliance tier of the nation's physician insurers. More good words on paper!

As for that tearful kindergartner, his college graduation was a few weeks ago. The setting may have been different, but many things were the same. There was pomp, circumstance, and more words on a piece of paper, and again some tears. This time, however, the tears were mine.

Tamara R. Fountain, MD, Chair of the Board



Servicing Your Account Online

Betsy Kelley, Vice President, Product Management

Have you ever wanted to look up your coverage information but the paperwork was somewhere else? Would you like to confirm that your payment was received and posted to your account? Do you need to provide your hospital with current proof of insurance? With MyOMIC Policyholder Services, you can perform each of these transactions, and more, on OMIC's website.

Accessing MyOMIC

To view your policy and account information and process transactions, you will first need to register on OMIC's website. Click "Register" at the top of any web page or go to the MyOMIC page and click "Create Account." When you register, you will create a user name and password and be asked basic information about yourself and your practice. At a minimum, you must enter your last name, state, zip code, and email address. Your client ID, which is listed on your insurance Declarations, must also be entered to gain access to MyOMIC features. If you are unable to locate your client ID, your underwriting representative can provide it. Should you ever forget your password, click "Forgot Password" on the login screen.

After successfully logging in, you will be taken to the MyOMIC page. Click "Enter" under My Policy and select the desired policy from your account list to access your account information. Details for the three most current policy terms are available.

Insureds

Coverage and premium information is available on the Insureds tab. If you are the policyholder, you will be able to access information about each insured under the policy. Non-policyholder insureds can access only their personal coverage information. For each insured

selected, MyOMIC Policyholder Services will display the insured type (e.g., solo dr, optometrist, solo inc), coverage classification, effective and expiration dates, retroactive date, liability limits, and premium (excluding taxes, dividends, or services charges) for the selected policy term. Within the coming months, this tab will also display the insured's rating state and county as well as a list of applicable manuscript endorsements, if any, and all discounts that have been applied.

Payment/Account Info

Although OMIC has offered insureds the option to pay their premium online for several years, MyOMIC Policyholder Services provides added functionality. Not only can the premium be paid online by credit card (Visa, MasterCard, or American Express) or with PayPal, but insureds can view the invoice amount, "pay in full" amount, and due date on the Make Payment/Billing Summary screen. As soon as the payment transaction completes, the payment will appear on the Payment History screen, which displays all payments made on the account, including the payment type, check number if applicable, and deposit date.

Certificates

Insureds can easily generate certificates of insurance for any existing certificate holder listed on their policy. As with coverage information, policyholders can process certificates for any insured currently covered under the policy, whereas non-policyholder insureds can generate certificates only for themselves. The user simply selects the certificate(s) desired from the displayed list of certificate holders and then clicks "generate COI." On the following screen, the user can view and print a PDF version of the certificate or email and/or fax the certificate to

themselves or directly to the certificate holder. The insured can even type a brief message to the recipient.

OMIC is developing functionality to allow insureds to add new certificate holders; this feature is expected to become available in 2015. We also plan to enable insureds to generate loss histories/claims experience reports in the future.

Requests

Under the Request tab, insureds can report changes in contact information or request other service. Because changes in address may affect premiums or coverage, changes in contact information are not automatically processed online. Instead, notification is sent to the underwriter, who will process the change or contact the insured for further information. Alternately, insureds can request a change in address directly from OMIC's website on the Policyholder Services/Make Changes page. Please note that editing your user profile will not update your policy information and OMIC will not be notified of such changes. Edits to the user profile are solely used for website registration purposes.

To request other services, go to the Request Service tab and select the change or information requested. Examples include adding a new certificate holder, changing class or limits, and adding or removing an insured. Enter your instructions or other pertinent detail in the Comments field. Changes in limits or coverage class may also be submitted from the Policyholder Services/Make Changes page of OMIC's website.

If you require assistance or have suggestions to further enhance your online experience, please contact your underwriter at 800.562.6642 or email us at omic@omic.com.

could be explored; defense counsel felt they would have posed problems for a successful defense).

Preoperative decision-making

Complications arising from surgical care would not have happened if the surgery had never taken place. Attorneys representing patients thus review the preoperative decision-making process carefully to determine if the surgery was indicated. In one case, a patient who experienced irregular astigmatism after implantation of a premium toric intraocular lens filed a claim. The defense expert felt that the surgery was indicated and had no concerns about the intra- or postoperative care, but questioned why the preoperative evaluation did not include keratometry, topography, or refractions from the patient's recent preoperative visits, which would have helped assess the amount and type of astigmatism prior to surgery. The patient did not pursue the claim and it closed without payment.

In another case, a patient sued after developing diplopia and excessive scarring when a lid lesion was removed. One defense expert felt that the scarring could not have been anticipated and that the patient had experienced a rare, idiosyncratic immune response. Another defense expert, who sees many patients with the same type of benign lesion, questioned the need to remove it. He also criticized the lack of documentation about why the surgeon decided to excise it, as the record did not contain any patient complaints about problems the lesion was causing. With the consent of the insured ophthalmologist, the case settled for \$95,000.

Informed consent

The adequacy of the informed consent discussion is often challenged in lawsuits. It is more difficult to obtain informed consent when the patient

has limited English proficiency. In one of the cases reviewed, a Spanish-speaking patient had cataract surgery complicated by posterior capsule rupture and anterior vitrectomy. He sued after losing all vision following a postoperative retinal detachment. The only consent form found in his medical record was for a clinical trial in which he was not a subject, and there was no documentation about the use of a translator during the informed consent discussion with the non-Spanish-speaking surgeon. While there was support for the care, the poor outcome and lack of evidence of consent convinced the ophthalmologist to settle the case, for which OMIC paid \$200,000. Documentation of consent for limited-English-proficiency patients should include the language in which the discussion took place and the name and relationship of any translators. OMIC has recommendations on the use of interpreters for both limited-English-speaking and deaf patients on our website.

Examinations and tests

A number of lawsuits would have been defensible if key exam elements had been documented. The most frequent problem stemmed from failure to document dilated retinal exams in patients who were later diagnosed with retinal detachments. In one such case, the ophthalmologist recalled dilating the eye but worried that the jury might not believe him, as he lived in an area where juries tended to side with the plaintiff. He decided to settle and OMIC paid \$100,000.

Another surgeon also reported performing a dilated retinal exam. At his deposition, he was questioned because his documentation was in two different colors. He testified that the documentation about the dilated exam might have been added after he learned that another ophthalmologist had diagnosed a retinal detachment. His case settled for \$320,000.

Another case involved a physician who was asked to quickly examine a patient for a colleague. She confirmed that the patient had a retinal detachment in the periphery and accordingly advised the patient to return to his retinal surgeon for the necessary operation. The physician considered this to be a "curbside consultation" and so did not document the encounter. The lack of documentation presented problems when she was later named as one of the defendants in a lawsuit. Regardless of her limited involvement with the patient, by examining him, she had established a physician-patient relationship for which a record was required. Fortunately for this physician, the plaintiff agreed to dismiss her from the lawsuit.

Telephone care

Ophthalmologists take after-hours calls from their own patients and those of their call partners as well as from emergency rooms when they are on-call. OMIC has regularly had to settle cases when the call has not been documented by the ophthalmologist, and his or her recall differs from the patient's account or what the emergency room physician documented. In one case, a patient called her ophthalmologist after LASIK surgery to report red, irritated eyes and was told to continue to take the drops prescribed to alleviate dryness. She called again while out of town to report worsening vision. She testified that the only advice she was given was to continue taking her drops. The physician recalls urging her to go the local emergency room but did not document either call. The patient developed an infection and corneal ulcer that left her with halos and night driving problems. The defense was complicated by the absence of documentation of the two phone calls as well as the lack of an operative note. As mentioned under "Operative report," this surgeon felt there was



no need for an operative report for uncomplicated refractive surgery. The case settled for \$50,000. Our website has contact forms for after-hours calls.

Contradictory records

Before the advent of electronic health records (EHRs), documentation deficiencies were predictable, stemming from illegible handwriting, missing pages, untimely entries, and questionable accuracy.¹ Problems also routinely surfaced with pre-dictated operative reports that, as noted previously, were not amended to address intraoperative complications. EHRs have successfully addressed the handwriting issues and have been credited with preventing some types of harm, such as medication errors stemming from wrong doses, routes, allergies, or drug-drug interactions. Nonetheless, EHRs have also created unintended consequences, including new sources of error and harm, as two OMIC cases illustrate.

In one case, a child presented to the emergency room, where the ER physician noted a dilated, non-reactive pupil with a shallow laceration in the lower lid conjunctiva. He diagnosed traumatic hyphema and contacted the on-call ophthalmologist, who asked that the patient see him in his office the next day. The ophthalmologist's EHR record from that outpatient visit indicated essentially normal findings of a round, reactive pupil without afferent pupillary defect (APD), and a white and quiet conjunctiva. The only abnormal finding was cell and flare in the anterior chamber, which led to a diagnosis of traumatic iritis. Before the recommended return visit, the patient lost vision and was seen by a physician covering for the ophthalmologist's practice. After eliciting a history of sickle cell disease from the mother, the second ophthalmologist asked her to bring the child right in. The vision was NLP, the pupil was fixed and dilated, IOP was 46, and there was a 4+ APD. Despite treatment, the child ended up

with HM vision and the parents sued. The ophthalmologist who initially saw the child reviewed his note and realized with dismay that the EHR had populated it with many normal findings. He fully intended to change the note later in the day but forgot to do so when his clinic got busy; indeed, it had never been signed as complete. There was no documented IOP, but the physician clearly remembered that he checked it himself when the staff member needed to leave the room to avoid becoming sick when the child vomited. The documentation problems, combined with criticism of his decision to treat the child over the phone instead of going to the ER, led OMIC to settle the case with his permission for \$380,000.

Similar problems surfaced in another case with EHR in which the plaintiff alleged a delay in diagnosis of a retinal detachment. On several visits, the exam findings contradicted the physician's assessment. Once, the findings showed cell and flare, yet the ophthalmologist discontinued the steroid drops and gave the patient a long follow-up period. The defendant physician explained he would never have stopped the steroids if the inflammation had continued and attributed the discrepancy in the records to use of the "carry forward" function, which automatically populated the record with the previous exam's findings. On another key visit, the findings showed normal retina vessels and clear vitreous, yet the assessment was retinal vasculitis, which had prompted the ophthalmologist to refer the patient to a retina specialist. Plaintiff experts and the subsequent treating physician felt that the retinal detachment had been present for some time yet was not detected by the ophthalmologist. Problems with the records helped convince the ophthalmologist to settle for \$290,000.

Risk management documentation strategies

In the event of a malpractice claim, the medical record often becomes the most important evidence used to determine whether or not the physician met the standard of care. While ophthalmologists have the opportunity to testify about documentation deficiencies, the plaintiff's attorney will use the discrepancies to challenge the ophthalmologist's credibility and diligence. This review of ophthalmic lawsuits shows that ophthalmologists need to pay particular attention to noting in the operative report any complications and how they were managed; the decision-making process when determining a diagnosis and course of treatment; informed consent discussions about risks, benefits, and alternatives of the proposed treatment; key pertinent positive and negative findings; and telephone conversations with the patient and other physicians.

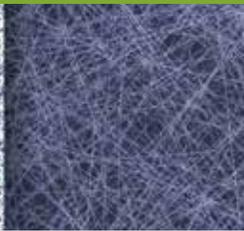
Electronic health records introduce new sources of error and confusion. A growing body of literature warns of the risks that certain features of electronic health records pose to the integrity of the medical record. An Institute of Medicine (IOM) report addressed what it terms "e-latrogenesis," defined as "patient harm caused at least in part by the application of health information technology (HIT)."² The IOM report, which analyzed events in hospitals, found many problems associated with the implementation of HIT, including inaccurate and missing data, but a low level of harm caused by it. OMIC's claims experience similarly shows that—so far—EHRs have mostly impacted the defensibility of the care. Please see the *Hotline* article for advice on how to ensure that EHRs produce accurate, reliable accounts of care.

1. Boyd D. "The Risks of Electronic Medical Records: Defending the Record." *ASHRM Forum*. 2013;Q3:4-5.

2. IOM. "Roadmap for Provision of Safer Healthcare Information Systems: Preventing e-latrogenesis."



Closed Claim Study



Allegation

Negligent retinal detachment surgery resulting in permanent retinal detachment.

Disposition

Case settled for \$190,000.

Surgeon Responsible for Unreported Adverse Event

Ryan Bucsi, OMIC Senior Litigation Analyst

Case summary

A 49-year-old female patient presented to an OMIC insured on an emergency basis with complaints of a dark semicircle and haziness for five weeks, which she described as a curtain over her left eye. Visual acuity was 20/80-1 with a diagnosis of rhegmatogenous retinal detachment requiring surgery. The patient was referred to another OMIC insured for the surgery. The first contact that the OMIC-insured retinal surgeon and his surgical assistant (another OMIC-insured ophthalmologist) had with this patient was on the day of surgery. This was the assistant's first day scrubbing in to a case. The surgeon informed the patient that his assistant would participate and assist in the surgery. The patient did not object. The surgeon and his assistant performed a repair of the retinal detachment in the left eye with 23-gauge pars plana vitrectomy, endolaser, cryopexy, and fluid-15% C3F8 gas exchange. The circulating nurse and surgical technician (both insured by the hospital) assisting the surgeon had done so for many years. The assistant introduced the surgical instrumentation into the eye. The principal stages of the procedure were virtually completed, including the trimming of the vitreous and vitreous base and release of traction to the retina breaks, when there was a sudden tugging of the cord connected to the light pipe while it was still positioned inside the eye. This caused the instrument to be dislodged from the assistant's hand. The full length of the probe ended up inside the eye. An iatrogenic linear retinal break superior to the optic nerve was noted. In a subsequent surgery, the surgeon performed a 28-gauge pars plana vitrectomy, membrane peel, retinectomy, silicone oil endotamponade, and sub-tenon triamcinolone acetonide injection in the left eye. Laser treatment around the retinal break was also performed. Despite the surgeries, at the time of the surgeon's last examination, the patient's retina remained detached and her visual field remained limited secondary to loss of blood flow to a large area of the retina encroaching upon the center. Final visual acuity in the left eye was 20/200.

Analysis

There was definite liability in this case but who would be held responsible? After receiving a notice of intent, the surgeon and his assistant claimed that it was the surgical technician who accidentally tugged on the cord, but there was no indication in the record that she precipitated the adverse event. The surgeon claimed that following the surgery he had discussed the event with another nurse at the hospital, but this was not documented and the nurse had no recollection of the conversation. OMIC defense counsel concluded that the two physicians would bear the brunt of liability in this case. Counsel noted that liability would have been clearer if, right after surgery, the event had been documented in the operative report and an incident report had been filed with the hospital. The surgeon claimed he did not want to upset the tech, who he felt would have taken it very hard. Counsel feared that a jury would take a negative view of the physicians' failure to document the tugging on the cord by the surgical technician until after they received an intent to sue. Both the plaintiff attorney and the hospital attorney could make the argument that blaming the technician was simply a way for the doctors to avoid responsibility. If a jury believed this was true, it could anger the jury and result in a higher than expected verdict. For this reason, the case was settled.

Risk management principles

The physicians could have avoided liability for this injury by documenting the event in the operative note and filing an incident report with the hospital following the procedure. Not doing so prevented the hospital and staff from learning from this adverse event and aroused suspicion when the surgeon later placed blame on the technician. The fact that there was no documentation of the surgeon's version of events until after a notice of intent was received made this case impossible to defend. Incident reports are generally part of a confidential peer review process; to protect their confidentiality, do not refer to them in the medical record or photocopy them.



Improving the Accuracy of Electronic Health Records

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

As the discussion of the two closed claims involving EHR in the lead article shows, records can become unreliable if steps are not taken to confirm the accuracy of the information. In a study that evaluated changes in the medical record of an ophthalmology practice when an EHR was adopted, the authors found that the length of the record increased due to copy-and-paste, copy-and-forward, and all-normal functionalities.¹ They raised concerns that the increased volume of EHR records would make it difficult to distinguish the critical findings from the background data and adversely impact the eye surgeon's ability to effectively diagnose and treat the patient. An editorial in *Ophthalmology* described the type of errors that EHRs can introduce, noting that they have created serious and unintended consequences that need to be identified and addressed immediately to ensure the integrity of the EHR.² Risk reduction strategies from these articles and other sources are discussed here.

Q What principles should guide the use of EHR?

A A basic principle is to "document what you do and only what you do."² Experts stress the importance of unique documentation for each patient encounter and warn that functions such as carry forward can lead to documentation of findings that were not actually seen.¹ This has implications for billing, as noted later.

Q Given the risk of erroneous documentation, may I use functions such as copy forward? If so, what are considered "best practices" for copying and pasting or carrying forward prior entries?

A Yes. Most articles reviewed for this issue of the *Digest* acknowledge the need for these tools, especially since adoption of EHRs has been shown, at least initially, to negatively impact the physician's productivity and decrease the number of patients seen in a day. Some documentation guidelines make a very useful distinction between historical data that is unlikely to change (what I will call "stable data") and information that is expected to change (what I will call "variable data"). Variable data can "only be presumed to be correct at the time the health care team member obtained it."³ Examples include the chief complaint, review of systems, physical examination, assessment, and plan, all of which will usually be different for each encounter. One organization allows each physician to copy forward his/her own variable data elements, but requires in its EHR policy that the physician edit the data to make them current. Furthermore, the organization prohibits physicians from copying variable data from the note of another physician. Other groups ban any use of the copy-forward function for variable data. Stable data elements include allergies, historical procedures and surgeries, previous medical history, previous developmental history, immunizations, family history, previous social history, and prior reports (pathology, cytology, radiology, procedures, etc.). One institution allows all EHR "authors" to copy stable data elements from prior entries whether or not the current physician obtained the information. It does caution that reports that are not new should be labeled as copies and that current reports should be prominently displayed.

Q Are there other risks besides inaccuracy if information is copied and pasted?

A The authors of the editorial in *Ophthalmology* noted not only the possibility of documentation errors, but also the risk of billing fraud. Indeed, the Office of the Inspector General of Health and Human Services (HHS) warned that some providers may be using the technology to game the system. For example, notes from office visits in EHR tend to be much longer and more detailed. Some computer programs incorporate the additional data elements into their billing algorithm and may inadvertently code the visit as more comprehensive than it actually was, leading to possible allegations of false claims and billing fraud. In malpractice lawsuits, plaintiff attorneys have also questioned how a physician could have obtained all the information recorded in a visit note in such a short time. Concerned about such billing and documentation issues, one organization asked its software vendor to program the EHR so that all copied data must be reviewed and verified by clicking on a button. If the information is not pertinent to the current visit, the policy states that the physician should not carry it forward into the current record. Physicians who use EHR systems without such a review button can use the free-text feature to indicate in their note that they have confirmed the accuracy of the data that has been carried forward.

1. Sanders DS, Lattin DK, Read-Brown S, Tu DC, Wilson DJ, Hwang TS, Morrison JC, Yackel TH, Chiang MF. "Electronic Health Record Systems in Ophthalmology: Impact on Clinical Documentation." *Ophthalmology*. 2013;120(9):1745-1755.

2. Silverstone DE, Lim MC. "Ensuring Information Integrity in the Electronic Health Record: The Crisis and the Challenge." *Ophthalmology*. 2014;121(2):435-436.

3. University of Illinois Medical Center at Chicago Documentation Guideline. Key Content Expert: David Sarne, MD, EMR Documentation Committee, http://chicago.medicine.uic.edu/compliance/comp_ppg/.



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Calendar of Events

OMIC is offering a variety of risk management courses throughout the spring. Upon completion of an OMIC online course, CD/DVD, 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 also listed on the OMIC website, www.omic.com.

Contact Linda Nakamura at 800.562.6642, ext. 652, or lnakamura@omic.com for questions about OMIC's risk management seminars, CD/DVD recordings, or computer-based courses.

JULY

22-27 OMIC Closed Claims. American Eye Study Club* by invitation. Four Seasons Resort, Vail, CO. Go to <http://americaneyestudyclub.org/>.

25 Lessons Learned from Malpractice Claims. Southeast Regional Annual Meeting: Alabama (ALAO),* Louisiana (LOA),* Mississippi (MAEPS),* Tennessee (TNAO).* Grand Sandestin Resort, Destin, FL; 7-7:50 am. Contact Mike Merrill at 334.279.9755 or go to <http://www.regionline.com/SEEye2014>.

AUGUST

3 Recent Trends in Malpractice Claims Against Ophthalmologists. Georgia Society of Ophthalmology.* Ritz-Carlton Hotel, Amelia Island, FL; 8-9 am. Contact Anita Amin at 404.299.6588 or go to <http://www.ga-eyemds.org>.

8 Identify & Manage Unhappy Patients. Michigan Society of Eye Physicians & Surgeons.* Grand Hotel, Mackinac Island, MI; 12:35-1 pm. Register at 313.823.1000 or <http://www.mispes.org/?page=29>.

9 Identify & Manage Unhappy Patients. Women in Ophthalmology.* Lansdowne Resort, Leesburg, VA; 12:30-1:45 pm. Register at <http://wioonline.org>.

SEPTEMBER

6 OMIC Closed Claims. Retina Institute Midwest Ophthalmologic Symposium. Eric P. Newman Education Center, St Louis, MO; post-lunch presentation. Register with the Barnes Eye Institute at 314.367.1181, ext. 2157.

11-14 OMIC Exhibit Booth. Retina Society Annual Meeting. The Union League, Philadelphia, PA.

12 Identify & Manage Unhappy Patients. North Carolina Society of Eye Physicians & Surgeons.* Charlotte Marriott City Center, Charlotte, NC; 5-5:45 pm. Register at 919.833.3836, ext. 111, or <http://www.nceyemd.org/>.

19 How to Avoid Misery & Malpractice from Unhappy Patients. New Jersey Academy of Ophthalmology.* National Conference Center at Holiday Inn, East Windsor, NJ; 1-2:20 pm. Contact Meagan Rosina at 609.392.1201.

20 Lessons Learned from Malpractice Claims. Table Rock Regional Meeting: Arkansas (AOS),* Kansas (KSEPS),* Missouri (MoSEPS),* Oklahoma (OAO).* Big Cedar Lodge, Branson, MO; morning session. Register at <http://www.tablerockroundup.org/registration>.