



HEALTHCARE

RISK MANAGER

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New: Exclusive Tools to Manage Your Risk, Employees

By: Dan Wright, VP Risk Management & Patient Safety

We're pleased to announce two new partnerships that will help you manage your practice – available to policyholders at no additional charge. As your medical liability insurer and practice partner, we're always on the lookout for new ways to help our policyholders.

MAG Mutual has negotiated to bring you exclusive, online access to the educational and informational resources of the ECRI Institute and HR Compliance SolutionSM. These tools can help you understand and improve patient safety in your practice and better manage and administer your Human Resources practices. Below are just a few features of each tool, but for more details, please visit our website, register and see for yourself what these exciting resources offer.

The ECRI Institute's Physician Practice Risk Management website helps you improve patient safety throughout your practice, and gives physicians and designated users access to independent and unbiased research findings, self-assessment questionnaires, and education and training programs. As a member, you'll also receive Physician Practice E-News twice a month, with concise articles about the latest patient safety and

risk issues as well as information on legal and regulatory concerns.

The MAG Mutual HR Compliance SolutionSM is an innovative resource to help protect your practice from employment practices lawsuits by giving you access to a wide array of Human Resources information, training and news. With ever-changing federal and state regulations, new employment laws and ongoing employee issues, you now can stay up-to-date quickly and simply. Users have access to online training, unlawful harassment information and tools to create a personalized employee handbook. Members can also receive *HR Express Update*, monthly informational newsletter and *HR Alerts*, keeping you abreast of the latest employment law issues.

Signing up is easy. Just go to www.MAGMutual.com, look for the banner: New Risk Management and Patient Safety Tools for MAG Mutual Policyholders! Click on the **ECRI Patient Safety or HR Compliance Solutions** website buttons. All you need to register is an email address and medical license or policy number. If you have any questions, please call **Cleveland Williams** at **1-800-294-5384** or contact him via e-mail at CWilliams@magmutual.com.

1 in 1,500 Pregnancies Affected By Cancer

By Linda Burke-Galloway, MD, MS, FACOG

One of the highlights during the National Medical Association's 2010 Conference, was a lecture on cancer and pregnancy given by Dr. Kevin Holcomb, of Weill-Cornell Medical College.

According to Dr. Holcomb, approximately 1 in 1,500 pregnancies are affected by cancer. However as women delay childbearing to ages 30 and 40, there is an increased incidence because the peak age of cancer occurs at age 40. Cervical cancer is the most common cancer found during pregnancy and usually presents as vaginal bleeding. A Pap smear done during the first prenatal visit should reveal the diagnosis. Dr. Holcomb

concluded, "when indicated, a colposcopy procedure performed during pregnancy is extremely important to detect invasive disease, which would then require aggressive treatment."

In my own clinical practice, I had a patient who had a low grade abnormal Pap during a previous pregnancy, but unfortunately the disease progressed to a high-grade Pap smear three years later with her current pregnancy. The patient is being watched very closely with repeated colposcopy procedures and has been encouraged to stop smoking which is a risk factor for cervical cancer.

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1 in 1,500 Pregnancies Affected By Cancer (continued from page one)

If microinvasive cervical cancer is detected, the pregnancy may continue to term, and a cesarean section is only necessary for obstetrical reasons. A post-partum hysterectomy is not usually necessary if the patient desires to have more children. If invasive cervical cancer is detected before 24-weeks, radiation therapy can cause a miscarriage 35 days after treatment in the first trimester and 45 days after treatment in the second trimester. If invasive cervical cancer is detected after 24-weeks, delivery is done by a cesarean section at term, and the patient then receives radiation therapy. The lower the stage of cervical cancer detected during pregnancy, the higher the survival rate. The bottom line is - **Pap smears save lives.**

Breast cancer is the second most common malignancy detected during pregnancy and affects 1 in 3,000 women. Twenty percent of women will have breast cancer before age 35. One to two percent of patients are pregnant at the time of diagnosis. The later the diagnosis, the worse the prognosis. A modified radical mastectomy is usually well tolerated during pregnancy. If the patient has a lumpectomy, therapeutic abortions do not improve the prognosis. Chemotherapy is used in advanced cases after the first trimester. If future children are desired, a two to three year waiting period is

recommended. Actress Christina Applegate is an example of a breast cancer survivor, now pregnant with her first child.

Melanoma is the third most common cancer diagnosed during pregnancy and ovarian cancer is the fourth. Ovarian cancer presents more danger to the mother than the fetus. An ovarian cyst greater than 5 centimeters detected during pregnancy requires surgery to rule out cancer, preferably done at 18 weeks. Most ovarian cancers found during pregnancy are stage one, which has a good prognosis.

In conclusion, although rare, cancer can occur during pregnancy. However early detection can save lives. A healthy pregnancy doesn't just happen - it takes an informed mother who knows what to do and when.

Linda Burke-Galloway, MD, MS, FACOG is a board-certified ob-gyn physician and a champion of patient safety. She is the author of *The Smart Mother's Guide to a Better Pregnancy* (Red Flags Pub/ 2008).

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Messaging Systems Improve Office Productivity and Patient Follow-up

By *Georgette A. Samaritan, RN, BSN*

Recent studies suggest that as many as 67% of patients occasionally miss appointments without notifying the office in advance. This gap in scheduling means unproductive downtime for the entire staff and a significant loss of gross income for the practice. A missed appointment may also result in a missed or delayed diagnosis, or a critical delay in required treatment.

Using a professional automated reminder system can provide quick payback by reducing loss of income due to "no shows" and last minute cancellations. The ability to bring in more patients for health screenings, vaccines or follow-up appointments is especially important, generating additional revenue for the practice, while maintaining control over your patients' treatment plans.

In addition, professional reminder technology provides the necessary documentation to confirm that sufficient attempts were made to contact the patient.

Some of the newer systems ask the patient to confirm receipt of the call by pressing a button or speaking into the phone. This is especially helpful for tracking and identifying patients who cancel multiple appointments and fail to follow-up.

In addition to call results reports, the actual messages and patient responses can be recorded and archived. This documentation might be invaluable if there was ever a need to provide this information in the future.

The latest systems offers the option to confirm appointments through text messaging and email, as well as voice reminders.

Using text messaging and email to connect with patients can provide a significant increase in the number of patients actually reached and confirmed.

According to the Pew Internet Project¹

- 78% of Americans own cell phones
- 89% of U.S. workers have a cell phone
- 65% of unemployed Americans have cell phones
- 19% have a Blackberry
- 59% of cell phone or Blackberry owners use text messaging
- 66% of Americans aged 30-49 use text messaging

Some professional reminder systems are available on a month-to-month basis, with an affordable per call rate, allowing practices to take advantage of the latest technology without making a huge financial investment.

MAG Mutual's Healthcare Solutions division can provide more information about evaluating and implementing a professional reminder system in your practice. For more information, call **Ruth Patten** at **1-800-282-4882 Ext. 5450**.

1. The Pew Research Center's Internet & American Life Project is one of seven projects that make up the Pew Research Center. The Center is supported by The Pew Charitable Trusts.

Meaningful Use of EMRs - Ten Things to Know

By Margie Satinsky, MAG Mutual Consultant

Since the passage of the American Recovery and Reinvestment Act (ARRA) in 2009, healthcare providers have been waiting for final rules regarding financial incentives for the “meaningful use” of electronic medical records (EMR). They have now been released and the much-awaited news is positive. Overall, the meaningful use criterion for hospitals and physicians has been relaxed, eligibility requirements for incentives have been expanded and the critical details of the incentive program and payout schedules have been clarified.

It is important that every physician understands what meaningful use means, how it works, and what your practice must do if you desire to apply for the Medicare or Medicaid incentive payments. Here are answers to to key questions about “meaningful use.”

- 1. What exactly is “meaningful use”?** Contained in the HITECH Act, part of ARRA, “meaningful use” of EMRs is a set of guidelines which must be met by hospitals and eligible professionals (EPs) in order to qualify for financial incentives under the Medicare or Medicaid programs. Here’s the logic: EMRs can potentially improve patient care, but just having EMR in your practice is not enough. You must use EMRs to collect and use “meaningful” information on clinical quality, and then use your information technology (IT) in a specified form and manner. Quality reporting and exchange of health information among different providers are important parts of the picture.
- 2. Who qualifies for meaningful use?** Is it the provider and/or vendor that provide the IT? Both the provider and the vendor must meet specific requirements. Providers must have and use technology that meets temporary and eventually permanent certification. It’s up to the vendors to obtain that certification. Providers themselves must use the certified software to report health information technology (HIT) and clinical quality measures. Because most vendors are tying promotional campaigns to certified software, providers may be confused about their own role. Vendors

don’t qualify for “meaningful use”; that’s a provider responsibility. Remember, certification of vendor software doesn’t mean that providers will automatically receive an incentive payment.

- 3. Do all physicians have to report the same information?** No - in response to public comment, CMS has retained the fundamental form of reporting on both HIT and Quality Objectives, but recognized that different physicians have different needs. For the HIT reporting, providers must report on 15 core reporting objectives and can select five from an additional 10 objectives. For the Quality Objectives, providers must report on three core measures and can select three other measures. The pathway to meaningful use is more individualized than it had been in the Interim Final Rule.
- 4. Is a provider who cares for both Medicare and Medicaid patients eligible for financial incentives from both programs?** No – take your choice, but don’t double dip. If a provider starts out by participating in one program and decides to change to the other, they can make only one change.
- 5. Are the ARRA incentives tied to the number of Medicare or Medicaid patients for whom a physician provides care?** Eligible Professionals who apply for the Medicare incentive payment are not required to see a specific percentage of Medicare patients. However, they must submit a minimum amount of Medicare charges in order to qualify for the full incentive payment. For example, in 2011 a provider must submit at least \$24,000 in Medicare charges in order to collect \$18,000. Eligible professionals who apply for the Medicaid incentive must meet specific volume requirements that are tied to the unique number of patients, not encounters. The Medicaid requirement is 30% and 20% for pediatricians. There are special requirements for federally qualified health centers and rural health clinics led by a Physician Assistant.

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Check Out Our Risk Management Web Page!

Under the **What’s New** tab, you’ll find new offerings such as: ECRI’s Physician Practice Risk Management Resource, On-Line CME Courses, Educational Modules for Physicians & Staff, and more useful resources.

Visit us on-line at www.MAGMutual.com and select
Risk Management & Patient Safety

Meaningful Use of EMRs – Ten Things to Know (continued from page three)

6. **If a provider receives financial assistance in purchasing an EMR, does that financial contribution impact eligibility of the Medicare or Medicaid incentive?** Yes – if a hospital or organization other than a state or local agency makes a direct financial contribution toward payment of the EMR, that money is subtracted from the financial incentive.
7. **Who makes the incentive payment to the provider?** CMS makes the incentive payment for both Medicare and Medicaid, even though the states administer the Medicaid program.
8. **How do providers prove meaningful use?** The approach for proving meaningful use has remained intact even though the Final Rule made some important changes. (See #3 above.) At the start, it will be sufficient to attest to the achievement of certain measures/criteria. It can also describe the way it uses the EMR. Eventually, proof of meaningful use will become more rigorous, and it is likely that providers will have to demonstrate that they are using what was described in the early phase of the program.
9. **Will providers need to turn their practices upside down to qualify for meaningful use?** Like any new program, becoming familiar with the requirements and developing methods for meeting them will take time. **However, many physicians already do what they must now document in order to receive a financial incentive.** Here's an example from the documentation section of the HIT Measures: Maintaining up-to-date problem lists, active medication lists, allergy lists, and keeping records that indicate preferred language, insurance, gender, race, ethnicity and date of birth, are common practice, as well as recording and charting changes in vital signs and smoking status. There's not much new here, however, meeting the requirements will require more thought and collaboration with your IT vendors. For example, lab tests must be incorporated into structured fields

within the EMR. Does the lab test requirement mean that the test results from each and every lab test must be entered separately, or can the results be integrated into the EMR in another way?

10. **What's the best place to get current information on meaningful use?** CMS has a new website (<http://www.cms.gov/EHRIncentivePrograms>) that contains up-to-date information. Starting in January 2011, this website will have a link to a registration form so providers can begin the application process.

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How are we doing?

The Editors of the Healthcare Risk Manager would really like your feedback on the articles and information we're publishing. We want to remain focused on your risk management interests and patient safety concerns. Please send your thoughts to: gsamaritan@magmutual.com or go to www.magmutual.com/RiskManagement/Survey/Vol16-No4/ to complete a short survey.

Thank you!

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