American Physicians Insurance Company

SUMMER 2009

PULSE

Anticoagulation
'COMMUNICATION CRITICAL'

Consider the following scenarios:

- When discharging a patient from the hospital, the nurse documents a followup date different than what the doctor tells the patient.
- Patient sees a physician and does not mention recent, frequent nosebleeds.
- A physician sees a patient for a new complaint and does not ask about current or new medications.
- An office or clinic fails to follow up on patient no-shows or cancellations.
- Hospital discharge instructions do not state the need for the patient to restart his outpatient medications for a chronic condition following surgery.

Now add Coumadin®, Lovenox®, heparin or any anticoagulation therapy to the equation…the risk from of these scenarios just shifted to critical.

The above points are taken from actual API cases where patients were injured due to a lack of communication at some point in the healthcare process. Those involved included physicians of differing specialties, nurses, families, patients, and office staff. Degrees of injury varied from moderate and temporary, to death (quite permanent). Causes of death ranged from stroke to exsanguination from a hemorrhage.

Discharging a Patient from the Hospital

When discharging a patient from the hospital on a new anticoagulation medication or new dosage, making a follow-up appointment prior to discharge is recommended. Make sure your office has an established policy and procedure to contact patients who do not show up for their appointment or cancel.

One particular area of vulnerability for most practices with anticoagulation patients is the new coumadin patient who is discharged from the hospital and forgets to keep (or make) his/her first appointment to check PT INR levels. If this were to happen (and it has happened in some practices), how would your office know and would this patient be identified so he or she could be contacted? Notwithstanding the obvious responsibility that lies with the patient, the prescribing physician has some degree of duty to follow up on a patient who is new to his or her condition requiring anticoagulation therapy. We recommend all practices have the ability to identify all new anticoagulation therapy patients.

Bridging Therapy: When transitioning a patient from IV or subcutaneous anticoagulation therapy to oral therapy, consider bridging until the oral anticoagulation therapy is at a desirable dose as determined by PT/INR levels. Document this plan in the patient's record.

Coumadin Clinic? Probably So.

Do you consider your practice as a Coumadin clinic? If you prescribe the drug, you are, whether you call it that or not. Read on…

Patient Education

Communication with patients on anticoagulation therapy is critical and should begin at the time the medication is prescribed and include, at a minimum, the following points:

> *'COMMUNICATION CRITICAL'*
> *Communication is critical to prevention, early identification, and treatment of adverse events related to the use of anticoagulants.*

(Continued on pg. 2)

(Continued from pg.1)

- Take the medication as prescribed
- Keep all followup appointments
- Keep all lab appointments to check PT/INR levels
- Dietary precautions
- Drug interactions, both prescription and non-prescription (OTC and herbal)
- Tell all healthcare providers at each visit that you take an anticoagulant
- For new anticoagulation regimens or dosage changes, PT/INR testing should be done every 2-3 days until a therapeutic level is achieved, and at regular intervals to assess PT/INR levels after that
- Pre/post op changes, confirmation of patient understanding the importance of compliance
- Non-compliance with follow-up appointments/no refills
- Signs of bleeding including excessive bruising, nosebleeds, gums bleeding, etc.
- What to do if bleeding occurs at home (i.e., Call for help, Quick Clot™)

When managing patients on anticoagulant therapy, education and communication of the above information should be documented in the patient's medical record. This list is not all inclusive. Consider having one or two staff specifically trained for this to assure consistency in the education provided.

Thoughts on Heparin

Does your facility have heparin testing protocol in place with USP guidelines? Does your hospital have protocol for DVT prophylaxis? If so, is it based upon physician evaluation or nurse assessment? When the assessment is done by an RN and then an order for prophylaxis is just signed off on by the physician, consider the contraindications which may be present based on a physician's clinical judgment and not known by the nurse. When patients are ill and have undiagnosed underlying conditions which may preclude DVT prophylaxis, physician judgment should be the deciding factor. Situations have occurred where the nurse administers the subcutaneous injection based solely on hospital DVT prophylaxis protocol and begins an irreversible anticoagulation nightmare which cannot be immediately reversed. Again, communication throughout the healthcare team is critical. Evaluate your hospital protocol.

For more information about the FDA's initiative to assess and mitigate risks associated with contaminated heparin go to http://www.fda.gov/cder/drug/infopage/heparin/default.htm. In addition, all heparin adverse events associated with the use of heparin are to be reported to the FDA via MedWatch. This can also be done via the site above or at www.api-c.com.

Patient Tracking

Routine ongoing monitoring of patient's PT/INR when they are on anti-coagulants is the standard of care. Failure to do so would be difficult, if not impossible, to defend if an adverse event occurred related to this. PT/INR testing should be done every 2-3 days until a therapeutic level is achieved, and at regular intervals to assess PT/INR levels after that.

A policy should be developed and implemented which outlines when and how to follow up with patients who miss their appointments. General recommendations are to attempt to contact patients who miss appointments (and do not reschedule) on a weekly basis. Patients who have just had a dosage change may need to be contacted sooner. Physicians within the clinic should establish the protocol and it should be consistent across all clinic locations. Although there is no "statute" or "requirement" for these timeframes, they are recommended because it shows due diligence on the part of the clinic as attempts were made to contact the patient to reschedule the appointment. There should be corresponding documentation in the chart which reflects the actions taken (i.e., phone call to patient, left message, missed appointment postcard sent, etc.).

A telephone call may be in order for patients whose follow-up visit may be more urgent due to dosage changes or prior potential critical values. If an adverse outcome occurred, it would certainly be more advantageous to the defense if there was documentation in the chart that attempts were made to contact the patient to reschedule. More importantly, patient safety will be improved. A copy of an Anticoagulation Services information sheet and tracking form for patients are available at www.api-c.com under Risk Management, Risk Management Resources, then White Papers and RM tools. Consider using these to enhance compliance and documentation for anticoagulation patients. Consider having your Coumadin patients read and sign this document. Feel free to alter the content to suit your practice and place on your own letterhead. If this is implemented, make sure to document the patient's acknowledgment of receipt of the information.

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API CASE ANALYSIS

ISSUE: Failure To Treat – Anticoagulation Therapy

Read, Record, and Go! For .5 credits Cat II CME

Who

Internal Medicine
Cardiovascular Surgeon
Cardiologist

What

This patient, with a history of stroke, who was currently taking Coumadin, went to see his internal medicine physician for a possible TIA. An MRI of the brain was ordered as well as a carotid ultrasound. The tests revealed no evidence of a stroke, but did indicate 60-80% narrowing of the left internal carotid. The internal medicine physician referred the patient to a cardiovascular surgeon for management. The cardiovascular surgeon referred the patient to a cardiologist for coronary and carotid angiography. The patient was advised at that time to stop taking his Coumadin 4 days prior to the procedure. The angiography confirmed the carotid stenosis, the surgeon sees the patient and recommends immediate carotid endarterectomy. The endarterectomy is performed the same day without complications, and the patient is discharged the next day. At discharge, the patient was instructed to resume his home medications and to follow up with the cardiologist.That evening the patient presented to the ED with complaints of blurred vision in the left eye, facial droop and weakness in the right arm and leg. Testing confirmed a carotid thrombosis and the patient was taken back to surgery. The patient continued to deteriorate and expired two days later.

Why

Failure to Treat. Allegations were that bridging therapy should have been administered and that simply putting the patient back on Coumadin postoperatively was not sufficient, nor timely enough to achieve therapeutic PT/INR levels post-operatively.

When

Postoperatively the patient should have been placed on parenteral or subcutaneous anticoagulant therapy to achieve therapeutic PT/INR while transitioning back to oral medication.

Where

Hospital

How

The physicians involved in the patients care failed to consider or communicate with each other regarding bridging therapy treatment for therapeutic anticoagulation in this patient, with a history of stroke that had been on Coumadin prior to the procedures. All physicians were named in the suit.

If you wish to request .5 Category I CME credits related to this Case Analysis…

Contact the Risk Management Department at API to request the full Case Analysis including a post–test and evaluation. Upon successful completion of the post–test and receipt of the evaluation, physicians may receive up to .5 category I CME credits.

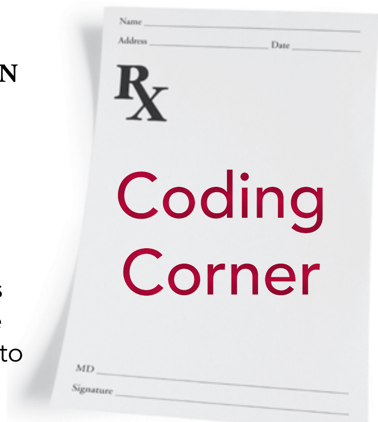
Physicians may contact the Risk Management Department at riskmanagement@api-c.com or 1-800-252-3628 to request the approved Category I Case Analysis.

Accreditation: American Physicians Insurance Company is accredited by Texas Medical Association to provide continuing medical education for physicians. The expiration date for this CME offer is June 1, 2010.

Risk Management Thought for Prevention

Bridging therapy should be considered for patients who have been off of oral anticoagulant medication for surgery to assure therapeutic PT/INR levels are achieved in a timely manner while oral medications are restarted. Bridging therapy could have greatly changed the outcome for this patient by increasing patient safety (reducing the risk of stroke) and therefore reducing the liability risk to the physicians involved.

For additional risk management information or educational opportunities, visit www.api-c.com and click on Risk Management Institute.



How to Survive the Economic Downturn

Physician offices are beginning to feel the effect of the current economic crisis. Many of their patients have lost jobs, taken pay reductions and many employers have reduced benefit offerings to employees.

The number of people with minimal coverage or high deductible plans is on the rise. How can your office become more efficient at collecting deductibles and co-payments at the time of service?

Here are a few ways to ensure better collections:

- Verify eligibility at each visit – many plans offer on-line verification
- Emphasize payment is expected at the time of service
- Request deposits for elective procedures

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Free On–Line CME

The API Risk Management Institute is pleased to present new FREE on-line CME offerings. Physicians can obtain both Category I CME credits as well as informal Category II credits.

Category I CME courses are now available on the API website for on-line review, printing or download. Topics include communication, documentation, and minimizing office risks. Also, look for more courses to be added in the near future!

Category II CME is now offered in a new "Read, Record, and Go!" format for the API Case Analysis which can also be submitted for Category I credit if desired.

For more information on the above CME activities and to sign up to receive the API Case Analysis by email, go to www.api-c.com and click on Risk Management. To speak with an API Risk Manager about any of these courses or for other risk management questions, call 1-800-252-3628.

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