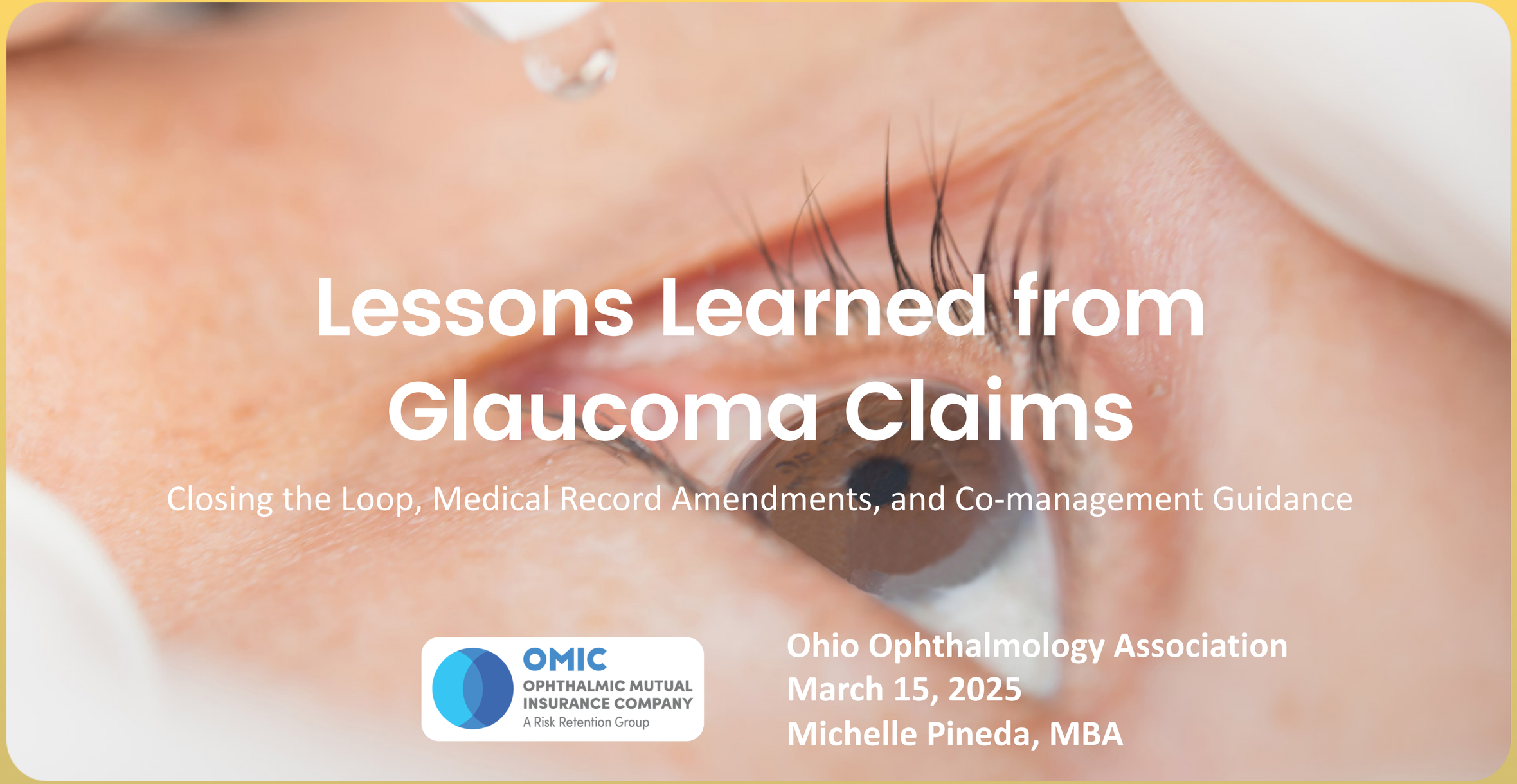

# Lessons Learned from Glaucoma Claims

Closing the Loop, Medical Record Amendments, and Co-management Guidance

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A Risk Retention Group

**Ohio Ophthalmology Association**
**March 15, 2025**
**Michelle Pineda, MBA**

# Financial

- **Presenter**

  Michelle Pineda, MBA
  OMIC Risk Manager


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# Learning Objectives

Upon completion of this course, participants should be able to:

**Understand medical record documentation amendments**

Promoting credibility of the record and reducing malpractice exposure.

**Implement safety protocols**

Close the loop on referral and test recommendations.

**Define roles and responsibilities**

Of healthcare team, including licensed and unlicensed staff.

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# Claims Statistics

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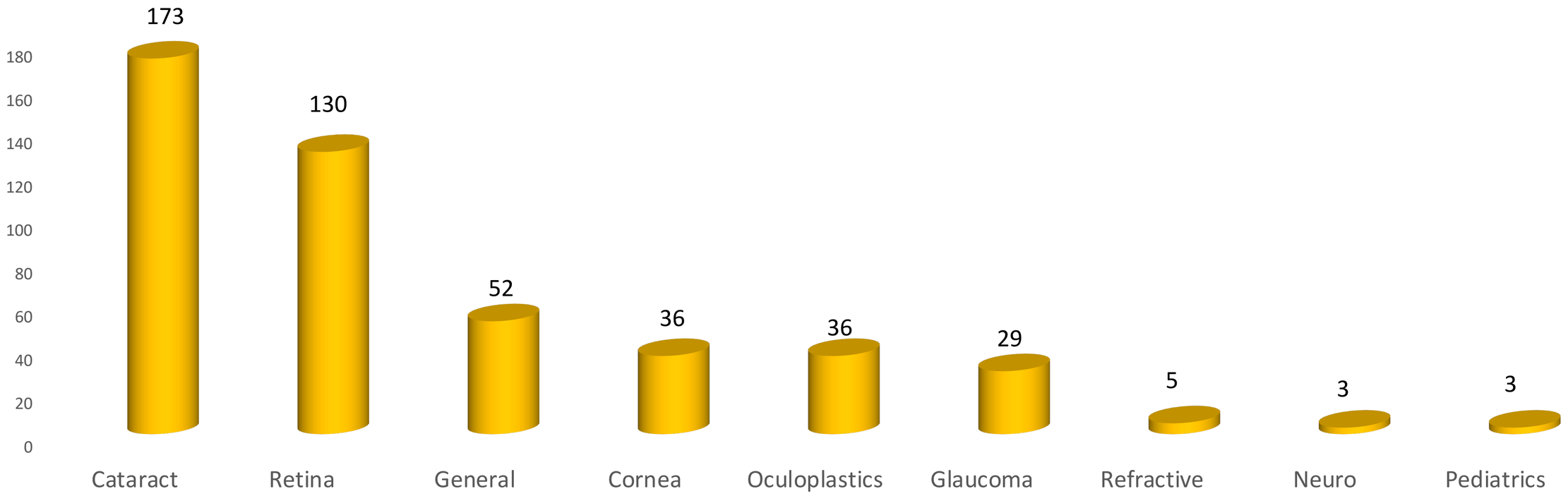
# Open Claims

By Specialty – January 1, 2025

Total 431

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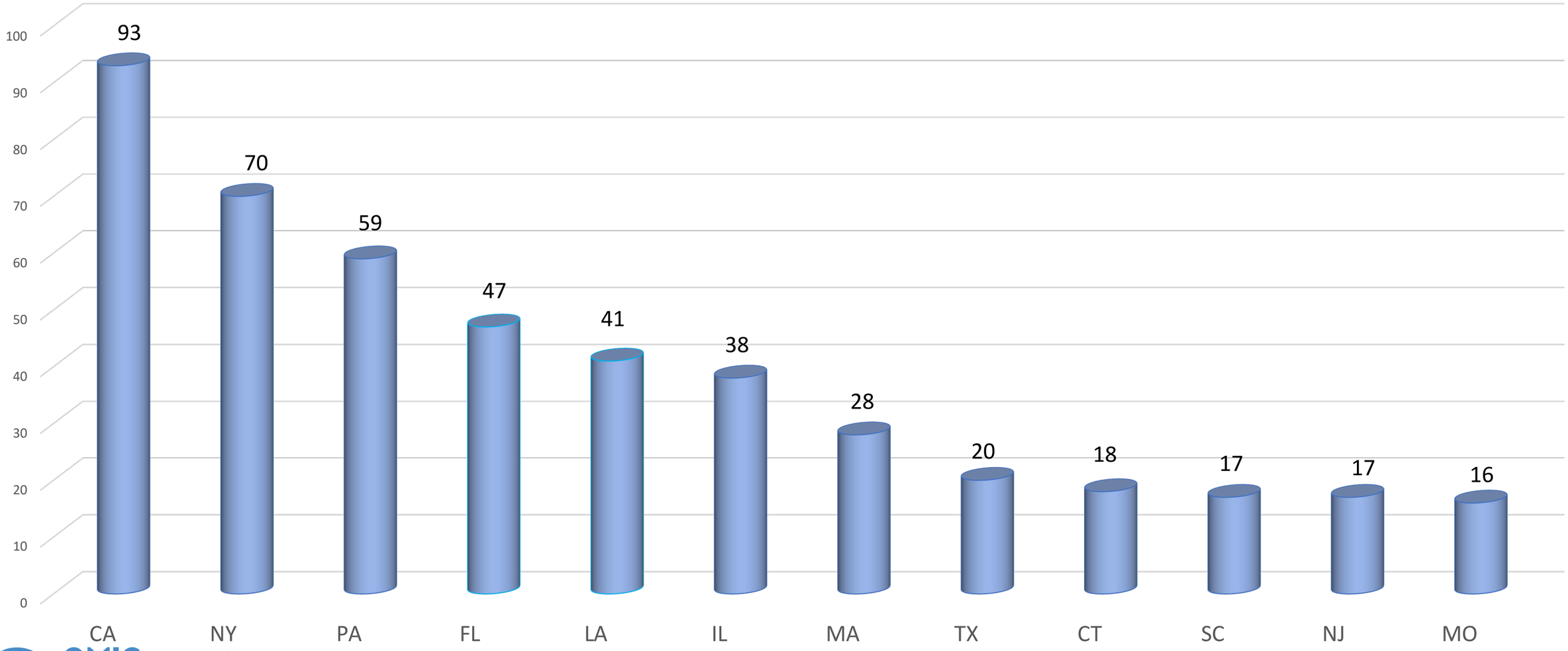
# Open Claims by State

As of January 1, 2025

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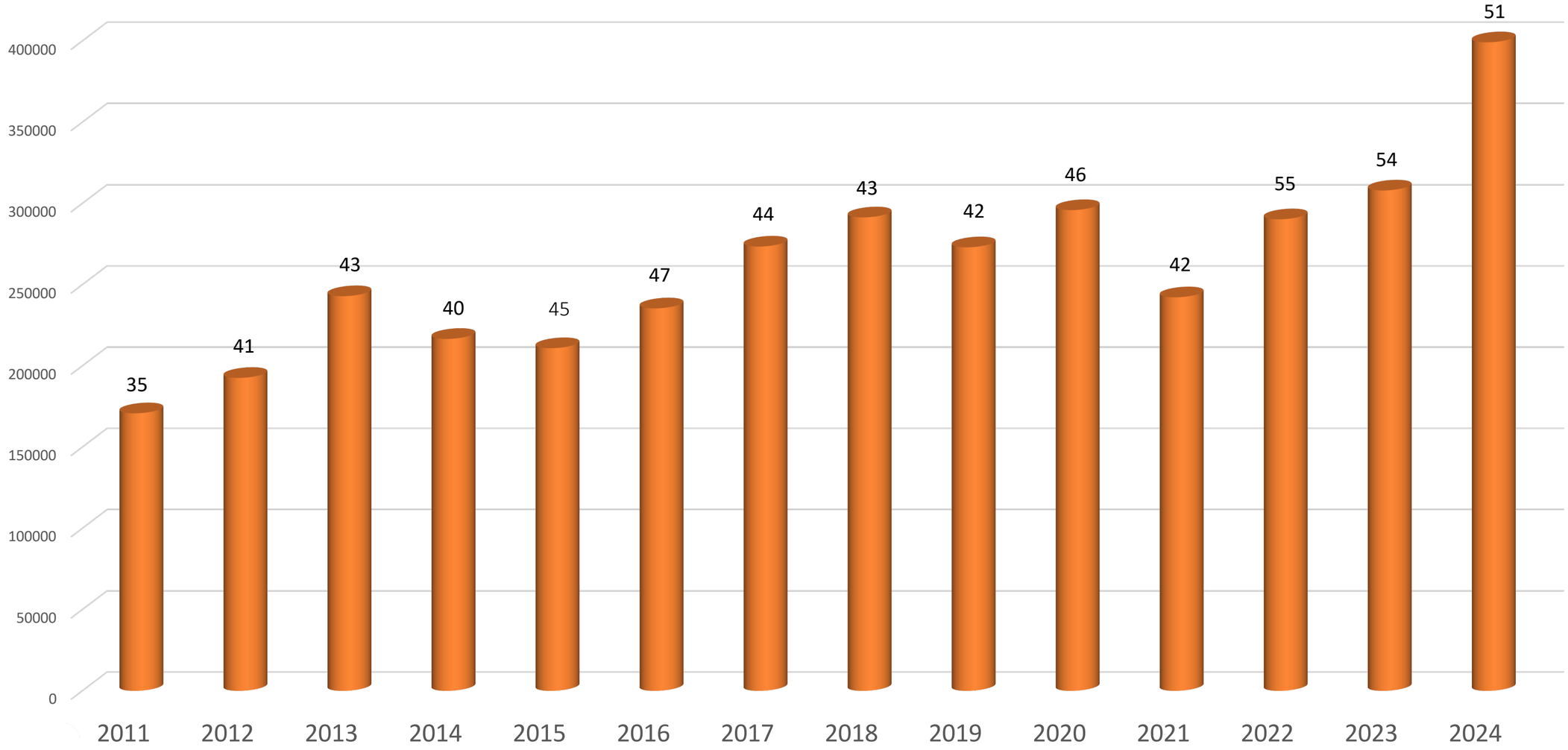
# Average Indemnity Payment

Settlements Per Year 2011 – January 1, 2025

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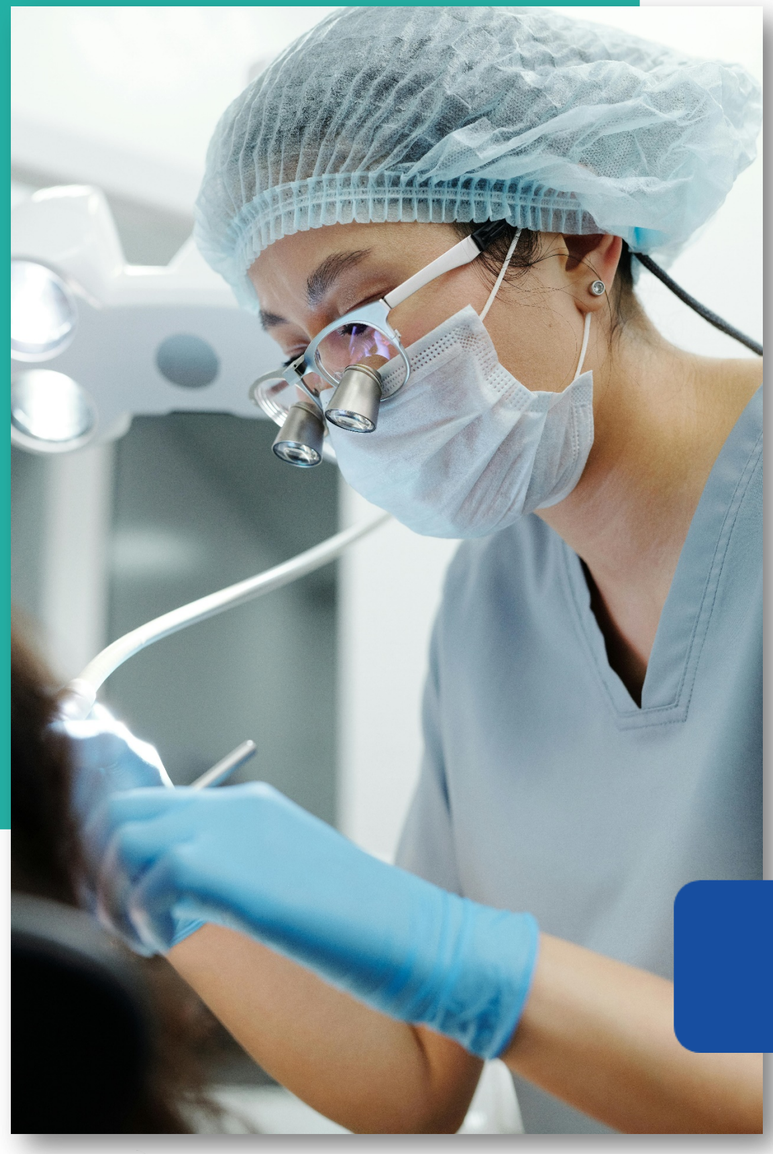
# Largest Settlements In OMIC's History

| Amount | Description |
|---|---|
| $3,375,000 | Failure to diagnose ROP resulting in bilateral blindness. |
| $2,600,000 | Failure to diagnose acanthamoeba infection OU resulting in bilateral blindness. |
| $2,500,000 | Failure to diagnose glaucoma resulting in severe bilateral visual field restrictions and blindness. |
| $2,000,000 | Failure to diagnose glaucoma resulting in unilateral vision loss. |
| $2,000,000 | Delay in diagnosis of optic sheath meningioma resulting in bilateral blindness. |
| $2,000,000 | 2.5-year delay in diagnosis of ocular melanoma resulting in death. |
| $2,000.000 | Failure to diagnose ROP resulting in bilateral blindness. |
| $2,000,000 | Failure to diagnose glioma OU resulting in bilateral blindness. |
| $1,900,000 | Failure to diagnose and treat Endophthalmitis post strabismus surgery resulting in a blind eye. |
| $1,800,000 | Failure to diagnose open angle glaucoma resulting in bilateral blindness. |



# Case #1

Delayed referral in a young patient with chronic uveitis

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# Chronolog

**Medical History:**
- 32 year old
- Patient for 9 years treated for resolved intermediate uveitis
- Treated with topical steroid and Kenalog injections
- Posterior subcapsular cataracts
- Intermittently elevated IOPs x 9 years
- Type II diabetes, uncontrolled

**Medications:**
- Prednisolone -(Pred Forte 1%) - long term
- Timolol - recent

| | |
|---|---|
| **Dec 20** | • **Complaints**: "I believe my vision is worsening."<br>• **Exam**: BCVA 20/20 OU<br>IOP OD: **35** OS: **32**<br>• **Impression**: Ocular hypertension OU. IOP elevated. May be steroid response<br>• **Plan**: Add Timolol 0.5% every morning OU; change Pred Forte to 4x/day OU. Follow up 4 weeks for IOP check. |
| **Feb 7** | • **Complaints**: (7 weeks later)<br>  • blurry vision OD > OS.<br>  • One month ago, black cloud over vision, right eye for one hour; returned early last week and remains.<br>• **Current meds**: Timolol 1 drop every morning OU; Pred Forte OU<br>• **Exam**: BCVA OD: **20/70** ; OS: 20/20<br>IOP OD: **38 (x 3)**; OS: 14<br>• **Impression**: Vision loss due to cataracts, monitor progression.<br>• **Plan**: Increase Timolol from every morning to twice daily. |

# Chronolog

| | |
|---|---|
| **March 7** | • **Exam:** IOP 35 OD, 13 OS<br>• **Plan**: Stop Timolol, add Cosopt twice daily and brimonidine three times daily<br>• **Return:** 10 days |
| **March 21** | • Vision stable, pressure down in right eye, but cup to disc inc.<br>• **Exam**: BCVA OD: 20/70 -same; IOP 23 OD<br>C/D ratio 0.6 OD<br>• **Referral:** glaucoma specialist |
| **May 2** | • **Complaints**: can no longer see out of right eye, cup to disc inc.<br>• **Exam**: HM OD, IOP 32 OD, C/D 0.95 OD<br>• **Dx**: primary open angle glaucoma, severe in right eye; likely responsible for vision loss<br>• **Rx**: add Rocklatan to Cosopt and brimonidine<br>• **Plan**: refer to glaucoma specialist ASAP |

# Care by Subsequent Treater

| | |
|---|---|
| **May 5** | • **1st visit with glaucoma specialist**<br>• **Exam:** Vision OD: HM; IOP 35<br>  • Posterior vitreous detachment OD<br>• **DX**: inflammatory open angle glaucoma<br>• **Plan**:  tube shunt |
| **May 10** | • **Procedure**: tube shunt<br>• **Exam**: LP OD and 20/20 OS; IOP controlled |

# Litigation

| | |
|---|---|
| **Suit filed** | • **Allegation:** failure to timely refer to a glaucoma specialist due to elevated intraocular pressure resulting in permanent damage to the optic nerve and loss of vision in the right eye. Should have referred by February 7th. |
| **Damages** | • Patient did not recover vision; remained LP in R eye.<br>• Increased difficulty performing job functions; difficulty driving at night.<br>• Must rely on family for help with many everyday tasks. |
| **Discovery** | • Physician recalled telling patient in March that a referral would be made to a glaucoma specialist and office staff would follow up with the patient. The referral was not made until 2 months later, when the patient was HM OD.<br>• The referral plan was inserted into the March visit note several months later.<br>• The patient's records request made prior to litigation produced records that did not show documentation regarding referral to a glaucoma specialist and revealed differences in IOP readings when compared to the insured's records produced during litigation. |

# Litigation

| | |
|---|---|
| **OMIC Review** | • Long course of steroids with periodically elevated IOP and no testing (HVF/OCT NFL) is below SOC.<br>• More aggressive treatment required in Nov/Dec when IOP rose to mid 20's and 30's.<br>• Documentation and EHR issues<br>  • some notes in EHR signed 6-8 months after date of visit<br>  • record alterations indefensible<br>• Insured consented and early resolution was pursued. |
| **Result** | • Settled for $2 Million |

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# Risk Management

Delayed: Referral > Testing > Diagnosis > Treatment

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# In Litigation…

86% of OMIC glaucoma claims that resulted in a settlement included one of these allegations:

- **Failure or Delay in Diagnosis**
- **Improper management of the treatment plan, including delayed referral to a glaucoma specialist**
- **Improper Performance of Surgery**
- **Improper Management of Surgical Patients**

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# Implement Protocol to Close the Loop

### Assess Processes

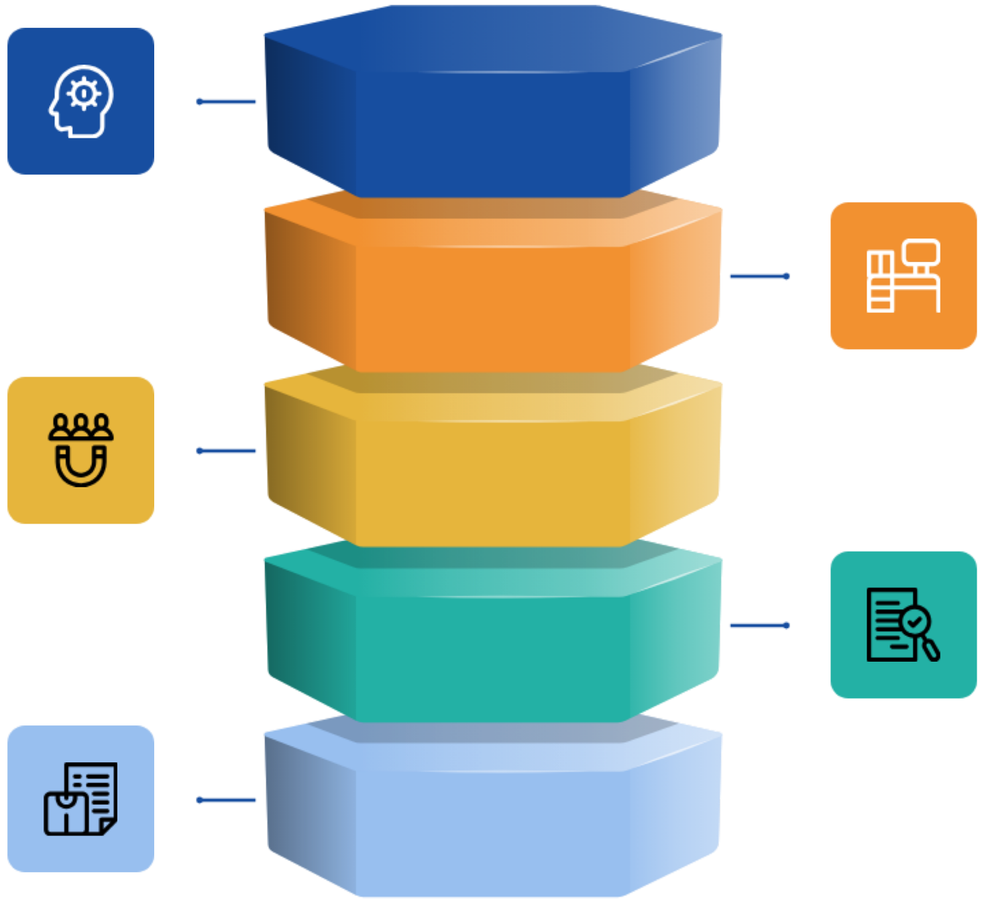
Identify bottlenecks and risks (e.g., missing test results, delayed notifications, patient compliance failure).

### Patient Engagement

Understand patient experiences and provide educational materials to involve them in the process to ensure compliance.

### Electronic Health Records (EHR)

Assess EHR capabilities in supporting tracking systems to close the loop for ordered labs, tests, or referrals.



### Office Readiness

Evaluate team attitudes, communication, and use of policies and procedures for patient safety and quality improvement.

### Documentation Audits

Ensure accurate and complete labs, tests, and referral documentation to prevent errors.

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# Follow-up Strategies

**01 Explain**

Explain your recommendations, including when to obtain, and the importance of compliance.

**02 Describe**

Describe potential consequences to vision if treatment is delayed or declined.

**03 Document**

Document the discussion.

**04 Implement**

Implement tracking systems to verify that patients obtain recommended labs, tests, and referrals.

**05 Establish**

Establish policies and procedures to close the loop.

**06 Develop**

Develop goals to ensure timely diagnosis and treatment.

**07 Terminate**

Terminate patient as a last resort for noncompliance.

# Risk Management

Late Sign-offs In The Medical Record

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# Late Medical Record Entries and Sign-off

## RISKS

**01 Credibility issues**

Compromises credibility, accuracy, and completeness.

**02 May lead to**

- Incorrect diagnoses
- Delayed treatment and referral
- Medication errors
- Inappropriate treatment plans

**03 Litigation Risk**

In litigation, late entries can cause the credibility of the entire medical record to be questioned.

## HOW to AVOID

**01 Review**

Review documentation to ensure accuracy and thoroughness.

**02 Complete ASAP**

Sign off at the end of each day or as soon as possible to ensure timely completion.

**03 Litigation Risk**

Leverage EHR features such as automated prompts to remind you to complete and sign off on patient records.

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# If You Use a

**Responsibility**

- Ultimately, the physician remains responsible for all clinical decisions and actions taken based on the documented information, even if a scribe assisted in the documentation.

**Review Documentation**

- Review and sign off on all documentation completed by the scribe to confirm accuracy and thoroughness.

**Confidentiality**

- Emphasize the importance of confidentiality and compliance with HIPAA and ensure adherence.

**Feedback and Evaluation**

- Providing regular feedback to the scribe can help improve their performance and ensure they are meeting the expectations of the role.

# Risk Management

Records Amendments

**Late entries**

**Addendums**

**Corrections**

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# In Litigation...

### Medical records scrutiny

Medical records, both paper and electronic, will be scrutinized by the plaintiff's attorney for any entries that suggest credibility is in question.

### EHR audit trails

EHR audit trails and forensic evaluations assist plaintiffs in proving an allegation of medical records credibility.

### Records alterations

Records alterations cannot be defended.

- **Late Entries**
- **Corrections**
- **Addendums**

These changes can be legitimate but must be done correctly to avoid any appearance that the change was intended to conceal or falsify what occurred. Such changes to the medical record should occur infrequently.

Organizational processes may be different depending on whether there are:

- transcribed reports
- direct data entry documentation
- draft documentation
- final signed documents
- scanned documentation

It is an important distinction for organizations to develop policies and procedures regarding these different processes in order to ensure the integrity of the health record.

# Making Amendments in Medical Record


## Addendum

Entries added to a health record to provide additional information in conjunction with a previous entry. The addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record, and be electronically signed.

## Correction

A correction is a change in the information meant to clarify inaccuracies (incorrect, invalid, or made in error) after the original electronic document has been signed or rendered complete.

.

## Deletion

A deletion is the action of permanently eliminating information that is not tracked in a previous version. Most EHRs do not allow permanent deletion.

## Late Entry

An addition to the record when a pertinent entry was missed or was not written in a timely manner. The late entry should be timely, bear the current date, time, and reason for the additional information being added to the record and be electronically signed. Similar guidance as addendums.

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# Late Entries, Addendums, and Corrections

When might these be necessary?

01

## Incomplete Note

The original note was not completed at the time of the patient encounter.

02

## Omitted Information

Crucial information was inadvertently omitted.

03

## Insufficient Detail

The documentation does not provide sufficient detail for one or more elements of the note, such as the differential diagnosis, plan, informed consent discussion, instructions to the patient, etc.

04

## Documentation Errors

There are errors in the documentation.

# Guidance for Record Management

## Contact for Assistance

Contact Risk Management for assistance.

## Establishing Policies

Policies and procedures should be established to provide guidance.

## Understanding Record Amendments

If you think you need to add to the record, be sure you understand how to do so correctly.

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# Case #2

Emergent Referral For Topiramate (Topamax)-induced Angle-closure Glaucoma

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# Chronolog

| | |
|---|---|
| **Jan 16** | • 35 YO presented to neurologist with 3-month history of migraines > prescription of topiramate (Topamax). |
| **Jan 24** | • Patient reported to neurologist she awoke with severe vision loss after double-dosing on topiramate the day before; then developed severe headache, nausea, and vomiting.<br>• Neurologist called ophthalmologist's office and requests that patient be seen that day for suspected topiramate-induced glaucoma.<br>• The patient was scheduled as a work-in at 3:15 pm for "blurry vision." |

# Chronolog

| | |
|---|---|
| **Later that day…** | • Patient arrived at **3 pm but** not brought to an exam room until **4:50 pm**.<br>• A **technician** dilated the patient with Neosynephrine 2.5%, Cyclogyl 1%, and Mydriacyl 1%. (Record later changed to Mydriacyl 0.5%.)<br>• **Exam by ophthalmologist**: IOP 54 mmHg OU; unable to perform a complete exam due to pain, discomfort, and photophobia; mild injection of the conjunctiva and corneal edema OU, anterior chamber shallow in the periphery; VA was counting fingers at 1 foot OU.<br>• **Tx:** Alphagan, Azopt, Lumigan, Betimol, Iopidine, Diamox, and Valium. Glaucoma meds given at 4:58 pm and 6:30 pm; no steroids administered.<br>• **Results**: at 6:49 pm, IOPs 49 OD and 52 OS.<br>• **Impression**: acute glaucoma, malignant glaucoma versus angle-closure glaucoma.<br>• **Plan**: physician called glaucoma specialist, who agreed to see the patient the next morning at 11:30 am. |

# Chronology

| | |
|---|---|
| **Jan 25** | • Patient seen by glaucoma specialist.<br>• **Exam**: IOP 44 OD and 46 OS; mild lid edema, pupil dilated OU.<br>• **Impression:** angle closure, history of topiramate use; laser iridotomy recommended.<br>• **Treatment:** bilateral iridotomy the same day; post: IOPs were 24 OD, 18 OS. |
| **Ongoing treatment and course** | • The patient continued care with glaucoma specialist(s).<br>• One year later, vision was relatively stable at 20/80; silicone plugs placed for dry eyes.<br>• Two years later, the cup to disc ratio of the right eye had increased to 0.5-0.6 OD; IOPs remained stable in the 17-18 range.<br>• Initial note was altered by physician when patient requested a copy of medical records approximately one year after event. |

# Litigation

| | |
|---|---|
| **Lawsuit** | • **Allegation**: delayed treatment of glaucoma and failure to lower IOP in a timely manner resulting in optic nerve damage and decreased central and peripheral vision. |
| **Damages** | • **Independent Medical Exam:** severe peripheral and central vision loss; VA 20/100 OD, 20/200 OS, no pinhole improvement. Mild cataracts. IOP 22 OD, 23 OS; cup to disc ratio .52 OD, .49 OS; OCT without significant nerve fiber layer loss. |
| **Retained Expert Opinions** | • **Delay** in seeing patient 2 hours after appointment and should have seen earlier.<br>• **Failed** to diagnose topiramate-induced glaucoma.<br>• **Failed** to stop topiramate and start cycloplegics/atropine and steroids to address corneal edema and presumed choroidal swelling.<br>• **Below SOC** to send patient home with elevated IOPs, with no appointment until the next morning (15 hours later). Patient should have been sent to ER for IV mannitol.<br>• **Alteration** of medical records indefensible. |
| **Result** | • Settled for $450,000 |

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# Risk Management

Records Alterations

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# Risk Management

The prior case illustrated the risk of an improper **late entry** in the medical record, while this case illustrates the risk of a late and improper **change** to the medical record.

## Legal Issue

An **improperly-executed change** to the medical records that is made in close proximity to a medical records request, and a long time after the event in question, will raise suspicions about the motivation for the change and its credibility.

## Pause

If you feel a change to the medical records is indicated before producing a copy of your medical records we strongly advise you to speak with Risk Management or your practice attorney.

# Risk Management

Telephone Screening By Unlicensed Staff

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# Telephone Screening by

## Key Concepts

01

### Information

The role of unlicensed staff is limited to gathering and transmitting information and assigning an appointment category.

02

### Cannot Engage in Decision Making

Unlicensed staff cannot engage in independent decision making or interpretation.

03

### Cannot Offer Opinions

Unlicensed staff cannot offer an opinion on cause of symptoms or treatment needed.

# Telephone Screening by

## Legal Risks

01

### Misinterpretation

Inadequate documentation and misinterpretation of patient information can lead to legal liabilities if a patient's condition worsens as a result.

02

### Supervision

Plaintiff may allege that screening calls without policies & procedures and physician supervision is the unlicensed practice of medicine.

# Telephone Screening Policies and Procedures

## Create policies for:

**Handling postop complaints**

**Patients who want to be seen ASAP**

**Physician referrals: emergent, urgent, and non-urgent**

And, how to handle emergent- and urgent-appointment patients when they arrive at the office

**Missed appointments and no-shows**

**When physicians want to be interrupted**

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# Telephone Screening Policies and Procedures

## Provide staff with:

**Physician-approved**

**A mechanism to report challenges or concerns encountered during screenings and with applying the policies**

**Ongoing training and supervision**

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# Sample Screening Form

## Patient Telephone Screening Form

Name of patient _____ Patient of Dr._____
Phone number _____ New patient: Yes/No
Time of call _____ Date of call _____ New referral from Dr._____
Name and title of staff member taking call _____

- What is your problem? _____
- When did your problem begin? _____
- How suddenly did it begin? _____
- Has the problem worsened, improved, or remained unchanged?
- Does it affect one eye or both? If one eye, which one? Right/Left
- Have you recently had surgery or a procedure? Yes/No
  - Type and date of surgery/procedure _____
- Has your vision changed? Yes/No
  - Loss of vision? Yes/No Constant/Intermittent
    - If yes, describe loss _____
  - Flashes? Yes/No Floaters? Yes/No Shadows in peripheral vision? Yes/No
  - Change in vision? Yes/No. (circle one and choose type)
    - Double vision? Distorted vision? Fading vision? Other:_____
- Eye pain? Yes/No Location, description, intensity _____
  - Has the pain worsened, improved, or remained unchanged?
  - Did nausea and vomiting accompany the pain? Yes/No
  - Is there any other type of pain? Yes/No
    - Headache Facial pain Jaw pain or ache Other: _____
- Are your eyes red? Yes/No
  - Has redness worsened, improved, or remained unchanged?
- Discharge from the eye? Yes/No. If yes, describe: _____
  - Eyelids stick together? Yes/No.
- Any burn/injury to the eye, forehead, or face? Yes/No
  - Eyelid damaged? Yes/No Pain? Yes/No Vision loss? Yes/No
  - Describe how burn/injury occurred_____
    _____
- Do you wear contact lens? Yes/No Glasses? Yes/No
- Any other problem? _____

Type of appointment: Emergent Urgent Routine

Date and time of appointment:

Ophthalmologist's advice or instruction:

# Example procedure

| COMPLAINT | EMERGENT | URGENT | ROUTINE |
|---|---|---|---|
| **FLASHES/ FLOATERS** | Recent onset of light flashes and floaters in patient with:<br>• Significant myopia (nearsightedness) : ask about history of LASIK or refractive surgery<br>• After surgery or procedure, or<br>• Accompanied by shadows in the peripheral vision. | Recent onset of light flashes and floaters without symptoms of emergent category<br><br>Many ophthalmologists prefer to see these patients the same day.<br><br>If in doubt, consult with the ophthalmologist. | Persistent and unchanged floaters whose cause has been previously determined |
| **REDNESS/ DISCHARGE** | Worsening redness or discharge after surgery or procedure. | Acute red eye, with or without discharge | Mucous discharge from the eye that does not cause the eyelids to stick together |
| | Redness or discharge in a contact lens wearer | Discharge or tearing that causes the eyelids to stick together. | Mild redness of the eye not accompanied by other symptoms |
| **OTHER EYE COMPLAINTS** | | Photophobia (sensitivity to light) if accompanied by redness and/or decrease in vision | Photophobia as only symptom |
| | | | Mild ocular irritation, itching, burning |
| | | | Tearing in the absence of other symptoms |
| **BURN** | Chemical burns: alkali, acid, organic solvents.<br><br>Give burn instructions. | | |

# Case #3

Delayed Diagnosis of Glaucoma in a Co-managed Patient

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# Chronolog

**MEDICAL HISTORY**

- High bp, MI, cardiac stents, thyroid disease, OU cataracts.
- 2005 Established patient x 10 years, start age 63.
- 2012 Treated by MD and OD for dry eye with topical tears, cyclosporin, punctal plugs, antibiotics, steroids and intense pulsed light (IPL) therapy.
- Sibling with glaucoma.
- Optomaps were performed annually to assess the back of the eye.
- Care provided by 2 ophthalmologists and 1 optometrist in the same practice.

| | |
|---|---|
| **Aug 2013** | • VA 20/30 OD, 20/50 OS; IOPs 14 OD, 16 OS<br>• Cataract surgery OD; goal distance vision on right side |
| **Sept** | • VA 20/20 OD, 20/50 OS; IOPs 16 OD 23 OS.<br>• Cataract surgery OS with Crystalens/Trulign IOL<br>• Immediate post-op complaint of blurry vision in both eyes, more in left with pain |
| **October** | • Continued complaint of blurriness ("like a layer of plastic over eyes") and dry eyes<br>• Abnormal Amsler grid, no visual field testing completed |
| **Dec** | • Patient felt dry eye was worse; VA 20/20 OD, 20/40 OS; IOP 9 OD, 12 OS |
| **Jan 2014** | • Piggyback lens placed. |
| **March** | • IOP spike to 32 OS; assessed borderline glaucoma with steroid response. |

# Chronolog

| | |
|---|---|
| **July 8 2014** | • Patient complained of dryness, burning, tearing, sandy and grittiness OU and continued floaters OD; visual field testing<br>• VA 20/20 OD, 20/25 OS; IOP: 10 OD 14 OS; cup to disc 0.3 OU |
| **July 24** | • Cup to disc ratio .4 OD .9 OS; OCT of optic nerves<br>• DX: normal tension glaucoma (NTG) OS>OD, exacerbated by pigment dispersion from piggyback lens OS and long-term steroid use. |
| **Aug** | • 2 iStents placed OS and piggyback lens OS removed; Glaucoma remained stable |
| **June 2015** | • Patient's last visit at the practice; VA 20/20 OD, 20/50 OS; IOPs 9 OD, 12 OS<br>• Glaucoma secondary to other eye disorders, left eye severe stage; long standing history of steroid use. |

# Litigation

| | |
|---|---|
| **Lawsuit** | **Defendants**<br>• 2 ophthalmologists, 1 optometrist, and their practice<br>**Allegations**<br>• Delay in diagnosis of low tension glaucoma<br>• Improperly implanted piggyback lens and delay in removal<br>• Improper refill of medications by staff (no physician oversight); failed discontinue steroids<br>• Failure to perform optic nerve exams (relied on Optomaps instead) |
| **Claimed Damages** | • Light sensitivity, which inhibits driving, daytime outdoor activities, and computer use<br>• Decreased depth perception resulting in tripping and falls.<br>• Needs assistance with ADL's. |

# Litigation

| | |
|---|---|
| **Retained Experts** | • All opined below standard of care (SOC).<br>• Evidence of developing glaucoma several years before diagnosis required visual field studies.<br>• Failure to monitor for glaucoma and changes to optic nerve.<br>• Physicians allowed the optometrist to perform Optomaps in place of comprehensive eye exams with evaluation of the optic nerve.<br>• Concerning changes on Optomaps not addressed.<br>• Non-physician staff authorized refills after physicians tapered and stopped steroids.<br>• Late diagnosis resulted in additional procedures and caused the condition to progress worsen. |
| **Result** | • Settled for $162,500<br>• 60% of liability attributed to practice secondary to system failures (including OD and vicarious liability), 40% to the physician. |

# Risk Management

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# Summary of Risk Management Issues

01

## Co-management (MD and OD)

- Lack of communication
- Lack of physician oversight of OD providers
- Lack of recognition of early glaucoma

02

## Failure to Diagnose

- Failure of OD to do optic nerve exams and follow the patient closely
- Failure to interpret studies
- Failure to conduct proper tests to monitor the patient
- Failure to diagnose.

03

## Lack Of Medication Refill Protocol

- Refills provided without physician authorization.
- Refills provided for medications that were previously stopped or limited (no reconciliation performed)
- Not all refills were documented

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# Risk Management

Co-management

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# Risks of Comanaged Care

### Miscommunication

Miscommunication between providers

### Diagnosis Delay

Delayed or incorrect diagnosis due to fragmented information

### Medication Errors

Medication errors arising from inconsistent treatment plans or poor documentation

### Symptom Patterns

Difficulty seeing patterns of symptoms and progression of disease

### Care Coordination

Poor coordination of care with other specialists

### Patient Confusion

Patient confusion regarding treatment plan

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# Co-management Protocol

01

OMIC recommends that all practices that work with optometrists (whether employees, independent contractors, or participants of a call group) have a written protocol.

02

The protocol should include:

- Role during office hours
- After-hours call (if applicable)
- Emergency Department call (if applicable)
- Ophthalmologist back up

03

All members of the practice should be allowed to review and comment on the proposed protocol before it is adopted.

04

Once implemented, the protocol should be reviewed and updated on a regular basis. Include an initial and ongoing training plan for staff.

# Co-management Protocol

05

Vet optometrists' education, licensure, and certification.

06

Understand state laws regarding optometrist scope of practice.

07

Define the role of optometrists when managing different categories of patients:

- Independently within scope of practice
- Patients that require consultation with an ophthalmologist
- Patients that require management by an ophthalmologist.

08

Set expectations regarding documentation.

09

Establish protocols for communication between optometrists and ophthalmologists.

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# Risk Management

Prescription Refill Protocol

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## 01 Problem:

- Non-physician staff approved refills without physician review, resulting in:
  1) Refills for medications that had been limited or discontinued by a physician
  2) Patient harm due to greater steroid use than planned.
- Not all prescriptions and refills were recorded in the medical record.

# No Standard RX Protocol

## 02 Root Cause:

- No description of roles, responsibilities, or steps for new and renewed prescriptions.
- Lack of physician review prior to submitting prescription.

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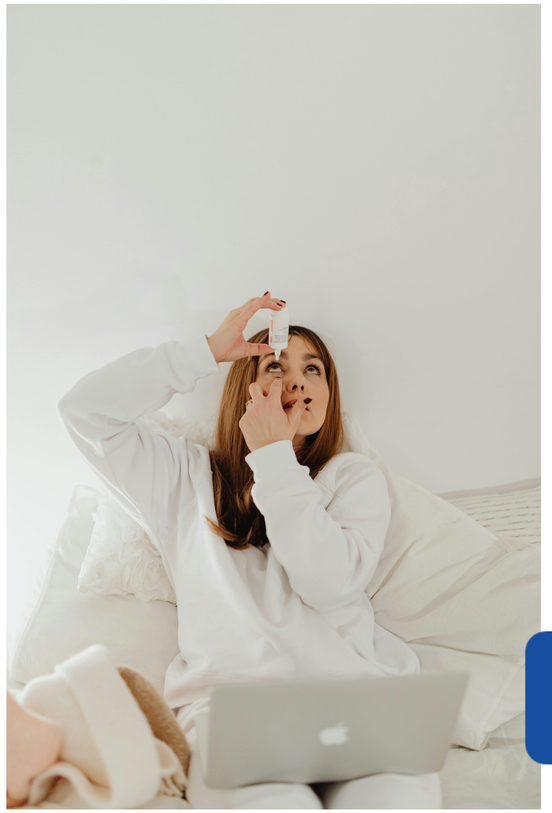
# Prescription Refill Protocol



**Documentation of Refills**

- Always document the number of refills allowed before the patient must return for a follow-up appointment.

**Staff Role**

- Define staff’s role in handling refill requests.

**Outline steps for:**

- Obtaining physician authorization for refills and new prescriptions.
- How to transmit the order to the pharmacy.
- How to document the transaction in the medical record.
- How to communicate to patients that a refill or new prescription has been denied until the patient comes in for a visit, and how to document the communication.

**Explain Policy**

- Explain your prescription refill policy to patients. You may wish to post the policy under FAQs on your website.

# In

**01**

Train all staff on policies and procedures to set expectations and ensure compliance and patient safety.

**02**

Develop policies and procedures for telephone screening for non-clinical staff and for co-management with other providers.

**03**

Audit to confirm compliance with protocols or to discover improvement opportunities.

**04**

Develop policies and procedures for guidance concerning amendments to the medical record.

**05**

Develop policies and procedures to close the loop on ordered labs, tests, and referrals.

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# Resources

## OMIC.COM

01 Documentation of Ophthalmic Care

02 Coordinating Care with Optometrists

03 Co-management of Surgical Patients

04 Telephone Screening Toolkit

05 Noncompliance Toolkit

06 Terminating the Physician-Patient Relationship Toolkit

- AHRQ.gov – Improving your Laboratory Testing Process
- HealthIT.gov – Test Results Reporting and Follow-up
- IHI.org – Closing the Loop
- AHIMA.org - Amendments in the Electronic Health Record

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# *THANK YOU!*

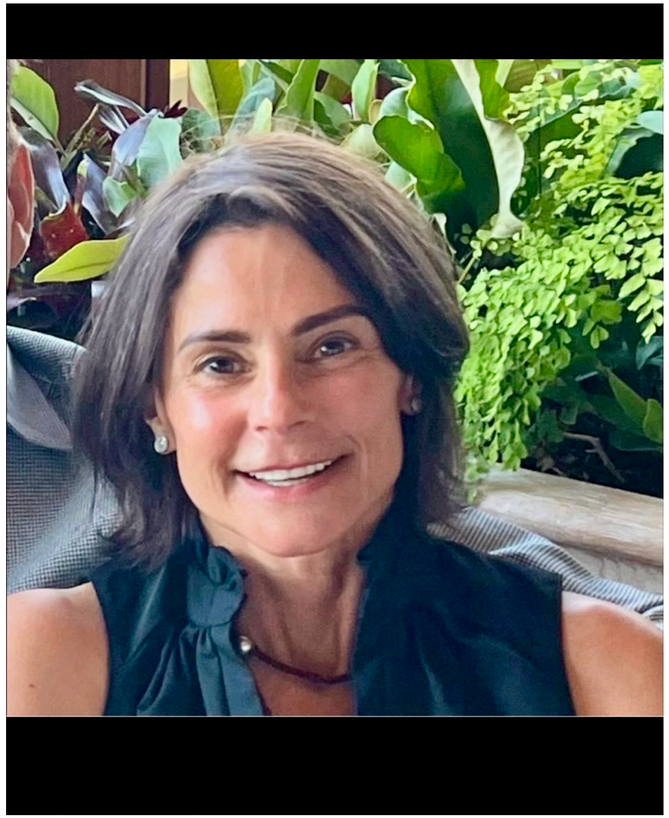
## Contact us:

riskmanagement@omic.com

800-562-6642

## Online resources:

https://www.omic.com/risk-management/



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