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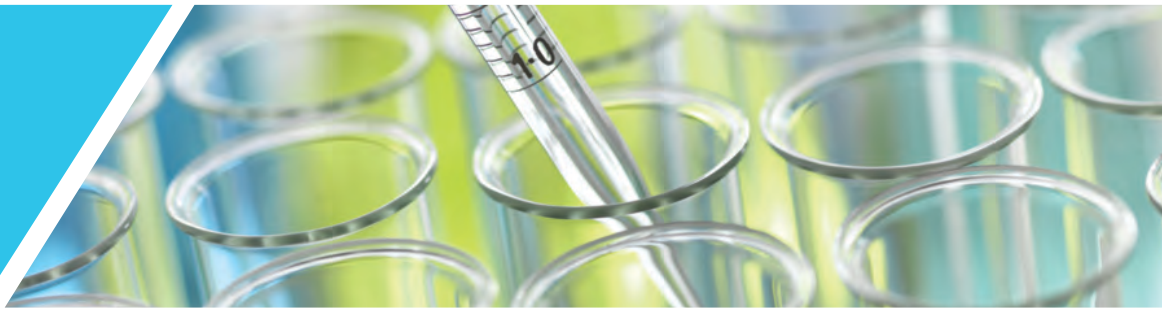

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Checklists: You documented it, but did you do it?

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Checklists are here to stay. There are convincing data which show that mandatory checklists prevent incorrect surgeries, incorrect medication administrations, testing the wrong patient, and thereby decrease the likelihood of bad medical outcomes. As Dr. Atul Gawande has persuasively written, checklists developed in industry but have been extremely helpful in medicine as well.

To be honest, I abhor checklists in medical practice and count myself fortunate to have not been required to use them, so far. I was never much on SOAP (Subjective, Objective, Assessment and Plan) either. I have seen the effects of checklists in many medical electronic medical records. There is a checklist developed by the American Academy of Neurology to guarantee better care of people with Parkinson's disease. It is a good list. I believe it will improve care, if carried out as intended, but cannot foresee myself, a specialist in Parkinson's disease (PD), actually using it. Have I recommended physical therapy within the past year? Have I asked about hallucinations if the patient is on medications? Have I inquired about sleep? I think there are 10 questions, and each is intended to be asked at least once yearly. I think I cover all of them more frequently than that, but it would be challenging to keep track of which ones I asked and which ones I skipped at each visit. But there is a problem with checklists. They encourage laziness. A quick click and a paragraph of printed material suddenly appears. I recall a neurosurgeon who generated three-page single-spaced notes on each office follow- up visit. This allowed him to bill at the highest possible level since every visit included a detailed note on the number of bowel movements per day, sleep habits, appetite and a zillion other aspects of life that had nothing to do with neurosurgery. In fact, I often could not discern what had taken place at the office visit. Why did he go? What happened? Was the patient better or not?

I recently was an expert witness in a malpractice case and immediately noted that each exam was exactly the same as the previous one. Like the common, "WNL" abbreviation in medical charts for "within normal limits," but frequently indicative of "we never looked," electronic medical records often contain the identical, carried-forward description of the medical examination and, oftentimes, the medical history. This often-used technique carries with it the high probability of undermining the intent of the EMR. Instead of documenting the exam, I find that it "undocuments" it. If every exam is the same (normal), was the exam actually performed? On the one hand, when the doctor actually mentioned the patient's mental status, the only time in twenty or so notes, I thought that the description of memory and cognition must be true, as this was the only time it was mentioned. But then I got to worry that perhaps this was the only time he clicked the box for "normal mental status," possibly meaning that it was normal, or possibly meaning that the patient was not too obviously impaired.

I recently reviewed a different neurosurgeon's note on a patient I saw in my office. He had been operated on for normal pressure hydrocephalus. This is a gait disorder often associated with cognitive and bladder problems. It always involves a gait disorder, however, and it cannot be diagnosed in its absence, yet the neurosurgeon's note from the last visit prior to surgery reported, "gait normal." In fact, all the notes of this surgeon on this patient noted that the gait was normal, and all the neurological exams were identical. How could the patient improve? Was the patient actually examined?

When I was a neurology resident we were required to record all our initial evaluations on a printed form several pages long; the first page was for the history, the inner pages for the physical and neurological exam and the last for assessment and plan. The neurological exam had boxes either for written information, describing orientation, language

function, memory, clock drawing, praxis and other mental status details, or tremors and other movements, as well as small boxes for entering the deep tendon reflex scores, whether various eponymal reflexes were present or not, images for dermatomal sensory loss, and boxes for entering the description of the gait. It was excellent training for me, and there were many nights when, while filling out a form, I realized I had to go back and assess something I had forgotten. After all, anyone reading my note would see an empty box and know that I had been incomplete, although, in truth, items could be left out if irrelevant. I suspect, although without any evidence to support it, that most of us think differently when clicking a box on a computer screen than when writing a number on a piece of paper, and certainly differently than when putting an observation into writing. I suspect, especially when there are a lot of boxes to click, that one tends to think, "I really don't have to ask about that. He would have told me if it was a problem. And I'm running late." Or something similar. I think a few boxes in an EMR probably work well. Did you document the presence or absence of falls? Did the patient see their PCP in the last six months? Has weight been stable? The problems develop when the number of boxes gets too large. One way of dealing with that is having the patient fill out an extensive checklist. I've seen those, too. I wonder if anyone actually reviews it. Excellence is often the enemy of the good.

We all have been drilled with the legal advice, "If you didn't chart it, it didn't happen." Unfortunately we now have the opposite problem. I wonder, "if it was charted, did it really happen?" ❖

Author

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*[**Editor's Note:** The Rhode Island Medical Society received a response from the American College of Emergency Physicians regarding a report issued by the Rhode Island Executive Office of Health and Human Services (EOHHS) recently.]*

Background

On February 10, the HealthFacts RI database, a new all-payer healthcare claims database, was launched. EOHHS released a report from the database which found that nearly 60 percent of all visits to Rhode Island emergency rooms in 2014 were potentially preventable.

The top reasons for emergency room visits varied by payer type, according to the report. Alcohol abuse, teeth disorders and upper respiratory infections were especially prevalent among the Medicaid population. Chest pain, dizziness and urinary tract infections were particular to the Medicare population. Neck sprains, headache and chest pain were among the top reasons for privately insured patients.

The database is a partnership led by EOHHS, with support from HealthSource RI, the Office of the Health Insurance Commissioner and the Rhode Island Department of Health. It includes claims information from all major insurers in the state.

Link to report

http://www.health.ri.gov/data/potentiallypreventableemergencyroomvisits/

American College of Emergency Physicians takes issue with report from new HealthFacts RI database

WASHINGTON — The American College of Emergency Physicians (ACEP) and its Rhode Island Chapter today jointly took issue with a new report by the state's Executive Office of Health and Human Services (EOHHS) HealthFacts RI database, about "potentially preventable" emergency visits, calling it irresponsible and saying it could put patients at risk.

The report assesses whether emergency visits could have been avoided, based on the patients' final diagnoses, not their presenting symptoms. This analysis does not take into consideration the national "prudent layperson" standard, which says emergency visits must be covered by insurance companies based on the patients' symptoms, not their final diagnoses. This standard was included in the Affordable Care Act (ACA).

"It is very alarming that a report like this is being issued that directly undermines language in the ACA and patients' responsible use of the emergency department," said **JAY KAPLAN, MD, FACEP**, president of ACEP. "Patients never should be forced into the position of self-diagnosing their medical conditions out of fear of insurance not covering the visit. This applies 20/20 hindsight to possibly life-threatening conditions – such as chest pain – and it violates the national prudent layperson standard designed to protect patients' health plan coverage of emergency care."

Dr. Kaplan adds that a report like this could lay down precedent barring emergency patients from receiving care.

The data in the EOHHS study does not correlate with the latest national data on emergency visits from the Centers for Disease Control and Prevention, which found 96 percent of emergency patients needed medical care within 2 hours in 2011.

"A report like this only serves to potentially scare patients away from the emergency department when they may need it most," said **CHRISTOPHER P. ZABBO, DO, FACEP**, president of ACEP's Rhode Island Chapter. "Both harmless and deadly conditions often have the same presentations. Asking patients to make that determination while at home, anxious, and with inadequate information, is a recipe for disaster."

A key finding of the RI report cites "chest pain" as representing the "greatest opportunity for savings."

Dr. Zabbo adds that this is a very dangerous message for the state of Rhode Island to send to its citizens. Patients with chest pain should get immediate medical attention to determine whether or not they are having a heart attack. If the doctor discovers it was muscle pain, upset stomach or anxiety/panic attack, it was still right for that patient to seek emergency medical care, and his or her insurance should absolutely cover the visit.

According to a study published in the Journal of the American Medical Association in 2013, researchers found that discharge diagnoses do not identify "non-emergency" ER visits. The small number of emergency patients who are ultimately discharged with "primary care treatable" diagnoses come to the ER with the same symptoms as other patients who need immediate or emergency care, hospital admission or surgery. ❖