Med-IQ® FOCUS

Keep your healthcare providers on the **cutting edge of emerging risks and trending topics...**

...by delivering bite-sized, hyper-relevant clinical risk information straight to the people who need it most—**your medical staff.**

The case-based, CME-accredited FOCUS is:

Consistent
Bimonthly with 24 editions per year

Targeted
Applies to a broad array of specialties

Timely
Informs on emerging risks and trending topics

Relevant
Provides immediate feedback and reflection opportunities for learners

Convenient
Brief, easy to access content for busy clinicians

Med-IQ® FOCUS

1 Each FOCUS begins with a question...

Med-IQ FOCUS Volume 292: Challenges of the 21st Century Cures Act

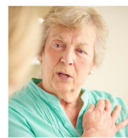
Consider
What duty do providers have under the Cures Act to ensure clear and consistent communication with patients?

2 ...then presents an actual redacted case from recent case law.

Challenges of the 21st Century Cures Act

Consider the following 3 brief case scenarios:

Case Scenario 1



A 74-year-old woman was seen by her PCP for persistent cough and generally feeling unwell. Her cough had been ongoing for the past 2 weeks and was not improving. Auscultation of the right lower lobe revealed coarse rhonchi. Given the physical examination findings, the PCP ordered diagnostic radiography that revealed findings concerning for a right lower lobe pneumonia as well as a 5-mm right upper lobe spiculated nodule. The radiologist report noted that the spiculated nodule was concerning given the abnormal morphology. The written report stated that clinical correlation was suggested and recommended repeat imaging. Under the Cures Act, the radiologist's report was released to the patient via the PCP's patient portal before the PCP reviewed the results. The nurse manager of the practice notified the PCP that the patient was calling the office and was emotionally distraught, convinced that she had cancer. The patient was frustrated that the PCP did not call her to discuss the result before she saw it via the patient portal.

3 This is followed by key takeaways that crystallize core concepts...

Challenges of the 21st Century Cures Act

Takeaway
Medical providers have a duty to their patients. This duty includes ensuring that patients have access to their medical records and control over their own healthcare. Educating patients about the immediate release of finalized test results and discussing medical diagnoses or jargon during the visit helps patients to be empowered about their own medical health. It also improves patient-provider trust, which can help decrease the risk of litigation.[4]

What can be learned from the experiences portrayed?

The Cures Act gives patients unprecedented access to and control over their medical records.[5] Under the Cures Act, the majority of patient medical documents, laboratory results, radiographic imaging reports, and pathology results are released to patients once finalized.

- Patients may have access to laboratory testing, procedure results, and radiographic imaging results—including incidental findings—before their provider reviews of the results; this may cause stress or anxiety
- Patients may interpret or misunderstand medical jargon or diagnoses, leading to unnecessary conflict and mistrust[3]
- Be mindful of the language you use in the medical record; be especially mindful when it comes to documenting behavioral health concerns because patients with these concerns may be particularly sensitive to what is written about them
- This stress, anxiety, or conflict may negatively affect the patient-provider relationship if preparations are not made in advance
- Patients can benefit by having direct access to their medical record, including[3]:

4 ...and reinforced with practical applications to clinician practice that can directly enhance patient safety and outcomes.

How might this be applied to practice?

- **Manage patient expectations—**Be sure to discuss with patients why you are ordering tests and what the results may show. Let patients know that they may receive the results before you have a chance to review them. Assure patients that you will call to follow up on any abnormalities once you have reviewed the results.
- **Access to information does not equal understanding information—**Discuss the use of medical jargon with patients, being mindful of any implicit bias. "Obese" carries a different meaning for medical professionals than it does to non-medical persons. Consider using alternative terms in your documentation to reflect neutral connotations (eg, BMI 32 instead of obese).
- **Ensure that medical record access does not change your relationship with your patients—**Patient-provider trust and communication are cornerstones to preventing dissatisfaction and litigious outcomes.[6] Furthermore, shared decision-making is part of the consent process and improves patient satisfaction.[3,6] The single most important factor when it comes to avoiding litigation is trust. "Our research shows that easy access to notes builds trust, even when errors are noted and corrected."[3] Be mindful of the language that you use to describe your patients and their concerns in their medical records, knowing that your patients may very well be reading what you write.

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