Risk management opportunities for Primary Care

1. Diagnostic assessment

Obtain a complete patient history and update regularly. Thoroughly address patient's complaints or symptoms. If you do not think the patient's presentation warrants diagnostic testing or consultation at this time, document your thought process and signs/symptoms/failure to improve within a given time period that would prompt further action. Establish a differential diagnosis; do not rely on a chronic condition or previous diagnosis to explain the patient's condition. Be aware of implicit biases and their impact on the diagnostic process.

2. Medication management

Follow federal and state medical board guide lines for pain medication management. Educate patients about the brand and generic names of medications they are receiving, their indications, usual and actual doses, expected and possible adverse effects, and drug or food interactions. Advise patients not to stop taking a medication without checking with you first. Reconcile medications at each patient visit. Be aware of whether co-treaters are prescribing for or monitoring the patient and clearly chart which medications you are responsible for managing. Monitor/assess the patient's adherence to their medication regimen and the patient's long-term physiological response to long-term medications.

3. Comprehensive follow-up systems

Document that a test, follow-up visit, referral or procedure was ordered. Confirm that they happened. Track results and communicate results to co-treaters and the patient. Document reminders to patients about follow-up tests and appointments. Contact patients about "no-shows" and work with them to overcome barrers to care such as transportation issues. When following up with patients, reiterate the potential risks of failing to obtain the recommended treatment.

4. SHAREd decision making

Seek your patient's participation. **H**elp your patient explore and compare treatment options. **A**ssess your patient's values and preferences. **R**each a decision with your patient. **E**valuate your patient's decision. Shared decision making improves the patient experience of care and adherence to treatment recommendations. (AHRQ)

Primary Care Case Study

A 76-year-old male established care with a new primary care physician. The patient's family history was significant for a first-degree relative's death from prostate cancer. The patient's initial prostate-specific antigen (PSA) level was 7.7 ng/mL; over the next three years, the PCP ordered repeat PSA tests that revealed rising PSA levels between 10.8 and 17.7. During this time, the patient declined digital rectal exams. Progress note documentation regarding PSA levels was limited to "labs reviewed," and no referrals or additional testing were carried out. Two years later, the patient self-referred to a urologist to address symptoms that he had attributed to benign prostatic hyperplasia. The urologist ordered a PSA test which revealed a significantly elevated level of 34.9, and subsequent MRI of the pelvis and prostate needle biopsy confirmed a diagnosis of metastatic prostate cancer with a poor prognosis. The patient filed a lawsuit against the physician, alleging that the failure to communicate the significance of the rising PSA values and to conduct annual digital rectal exams resulted in delayed diagnosis of prostate cancer and decreased life expectancy. The physician claimed he had multiple discussions with the patient about his rising PSA levels, but the patient and his wife denied this. Documentation was sparse regarding discussion of the PSA results and their relevance, increased risk of prostate cancer due to family history, the need for a Urology referral, or the patient's informed refusal to undergo digital rectal exams. **The lawsuit was settled on behalf of the physician for $1 million.**

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