

# Claims **Rx**

clinical & risk management perspectives

January 2010

## Preventing Early-Onset Group B Streptococcus (GBS)

### CME Information

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### Learning Objectives

The case study and risk management recommendations presented in this article will support your ability to:

- Adhere to applicable standards to screen and manage pregnant patients colonized with Group B Streptococcus
- Implement risk management best practices to facilitate communication, follow-up and documentation of care

### Target Audience

Providers who treat pregnant patients

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Dear NORCAL Mutual Policyholder:

We are pleased to kick off the New Year with an edition of *Claims Rx* focusing on one of the leading causes of infection-related death and illness in newborns, invasive Group B Streptococcus (GBS). As always, you will find “real-world” case studies that highlight the risks to both patient safety and your practice—and recommendations for reducing such risks.

As a special insert for this issue, at the back you will find risk-reduction strategies for managing patients who may have been infected by the H1N1 virus. By setting up clear protocols for your staff—on screening phone calls, identifying high-risk patients for special monitoring, tracking vaccinations, etc.—you can safely navigate this flu season with optimal outcomes for your patients and peace of mind for you and your team.

The range of risk-management issues slated for *Claims Rx* in 2010 is broad and timely. To name only three, we will share best practices with you on managing risks associated with:

- Disruptive patients
- Prostate cancer
- Electronic health records

To further enrich our continuing medical education (CME) program, we will introduce four new courses this year:

- Failure to Diagnose Malignant Melanoma
- High Alert Conditions (focusing on four conditions frequently seen in malpractice claims)
- Stroke (focusing on four major liability risks)
- Litigation Stress (focusing on four areas of associated risk)

Our goal at NORCAL Mutual is to support you and your fellow policyholders with the best risk management and CME programs possible. As always, we welcome your feedback, constructive criticism and suggestions for worthwhile topics for future issues of *Claims Rx*.

Sincerely,



Stephen M. Farber

Vice President, Risk Management and Continuing Medical Education

## Introduction

In the 1970s invasive Group B Streptococcus (GBS) was identified as one of the leading causes of infection-related death and illness in newborns. It is estimated that up to 30% of child bearing women are colonized by GBS. Vaginal or anorectal carriage of GBS can result in passing the bacteria to the infant during labor and delivery. During the 1980s, several clinical trials showed that early-onset (defined as infection occurring before seven days of life) infantile GBS could be prevented if mothers who were carriers of GBS were administered intrapartum antibiotic prophylaxis (IAP).

In 1996 the Centers for Disease Control and Prevention (CDC), American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) released consensus guidelines for the prevention of early-onset GBS infection. These guidelines gave providers a choice of recommending IAP on the basis of either a set of risk factors or on GBS screening results. Prior to these preventative efforts, an average of 8,000 newborns (1.7 cases per 1,000 live births) developed early-onset GBS infection annually in the United States. An average of 300 infants died from it. Widespread implementation of the 1996 guidelines was associated with a 65% decrease in the incidence of early-onset GBS.

Additional research since 1996 indicated that a screening-based prevention strategy was more effective than a risk-based strategy. Thus, the CDC updated its guidelines in 2002 and recommended that all pregnant women be screened for GBS, and that GBS carriers receive IAP. Both ACOG and the AAP endorsed these new recommendations.<sup>1,2,3,4</sup>

The incidence of early-onset GBS has further decreased to approximately 0.4 cases per 1000 live births.<sup>5</sup> However, it continues to be the leading cause of neonatal bacterial infections in the United States.<sup>1</sup> In fact, the 2002 guidelines point out that even the most stringent adherence to the guideline recommendations will not completely eradicate GBS;<sup>4</sup> however, recent research indicates that there are various avenues for improvement.<sup>1</sup>

Because the cost of GBS screening and IAP are minor compared to the toll of neonatal GBS infection, providers are encouraged to be especially diligent and careful to medicate GBS-positive pregnant patients appropriately.

This *Claims Rx* presents strategies for accurately and consistently identifying pregnant patients colonized with GBS and keeping those patients from infecting their infants during labor and delivery.

## Addressing the Gaps in Preventive Measures

The strategy outlined in the 2002 CDC early-onset GBS guidelines contains two basic elements:

- All pregnant women must be screened for GBS. (According to a recent study discussed in a *New England Journal of Medicine* article, 18% of the early-onset GBS cases in term infants occurred in unscreened women.<sup>1</sup>)
- Women who are positive must receive appropriate IAP.<sup>4</sup>

Unfortunately, it is more difficult to accomplish these two guideline elements than it would appear. Universal screening can be a daunting task in busy health care settings. The timing of the screening is important. The CDC recommends that the test be done between 35 and 37 weeks gestation.<sup>4</sup> If the test is done before then, there is a chance the mother will become colonized later in her pregnancy. If the test is done later, there is a chance she will deliver before being tested.

Furthermore, because women can be colonized in both the vagina and rectum, a peri-rectal swab must be done in addition to the introital swab<sup>4</sup> but not all providers do a peri-rectal swab. Even when the specimen collection is appropriate, if the proper laboratory technique is not used, a false-negative result may be returned. According to CDC protocol, the cultures need to be incubated in a selective broth for 24 hours before undergoing the usual 48-hour culture process.<sup>4</sup> The additional 24-hour broth greatly improves the culture pick-up and reduces the number of false negatives—but not all labs follow the CDC protocols. Even when a positive result is returned, for various reasons it may not be included in the patient's labor and delivery chart (e.g., see the following case study).

Taking all of the pitfalls into account, the logistics of early-onset GBS prevention may seem overwhelming. However, providing IAP to any patient with an unknown GBS status and injecting some basic risk-management strategies into the process of screening pregnant patients for GBS may go a long way in further decreasing the incidence of this devastating disease.

(continued on page 4)

## **Case Study #1**

### **Allegation: Failure to provide chemoprophylaxis at admission resulted in the death of a newborn male from GBS sepsis.**

The patient was seen by her obstetrician (OB) for regularly scheduled prenatal visits throughout an unremarkable pregnancy. In her prior pregnancy, the fetus had been overdue and at birth had weighed 10 pounds. Due to the fetus' macrosomia, he was delivered via C-section. Because the patient wanted to avoid a repeat C-section, the plan was to induce labor prior to 40 weeks to avoid macrosomia. A GBS screen was done at 37 weeks, which was positive. However, the OB was not informed of the results and they were not in the patient's chart at the hospital when the doctor arrived for the planned induction three weeks later.

After two doses of prostaglandin gel failed to initiate labor, the OB started Pitocin. Labor proceeded rapidly from then on. At 10 a.m. on her third day of hospitalization, the patient gave birth to an 8-pound male infant via spontaneous vaginal delivery. APGARS were 6 at one minute, 6 at five minutes and 8 at ten minutes. At birth the baby was noted to be grunting and having respiratory difficulties (he was rated a "1" for respiratory efforts at one minute, five minutes and ten minutes). He was given 100% oxygen by nurses via continuous positive airway pressure mask and was transferred to the intensive care nursery. The OB called the neonatologist for consultation.

The neonatologist started the infant on hood oxygen and ordered a chest x-ray and complete blood count (CBC) with differential. The chest x-ray was normal. The CBC showed an elevated band neutrophil count of 15 (normal = 0–4), a decreased polynucleated neutrophil count of 44 (normal = 51–71) and a white blood cell count (WBC) of 12,600 (normal = 3,900–10,000). The neonatologist interpreted these results as essentially normal and felt they did not indicate an active infection.

The neonatologist questioned the OB about whether the mother was GBS positive or negative, but the OB could not find test results in the hospital chart. Unable to remember whether the test had been ordered, he assumed the results must have been negative because there were no results in the chart. He told the neonatologist that the

mother was not in a high-risk group for GBS and that he assumed she was negative.

By 7:30 p.m., the infant's CBC results revealed a WBC of 700. The neonatologist ordered a cerebrospinal fluid (CSF) draw, with culture and sensitivity; Gram's stain; glucose level; protein and cell count. Ampicillin and Rocephin (ceftriaxone) were given. The lab results were received at 10 p.m. They were markedly abnormal. The infant's urine cultured positive for GBS. By 7:00 a.m. the following morning, he was dead.

Around the same time that morning, the OB went through the mother's chart at his office and discovered the positive GBS results. He immediately informed the neonatologist, who then rechecked the patient's labor and delivery records. The GBS results had also appeared in that chart.

The parents of the deceased infant filed a wrongful death lawsuit against the OB, the neonatologist and the hospital. They alleged that the failure to diagnose and treat the infant's GBS infection resulted in his death.

## **Discussion**

The tragic outcome of this case might have been avoided had lack of communication and follow-up failures not gotten in the way of the mother receiving chemoprophylaxis at admission and/or the neonatologist acting on the mother's positive GBS results. The OB in this case wrongly depended on the mother's low risk status and lack of strep B results as adequate evidence upon which to conclude that the mother was not colonized. In other ways, however, he followed current CDC guidelines for a patient delivering at term with unknown GBS screen results. According to the guidelines, "If the result of GBS culture is not known at the onset of labor, intrapartum chemoprophylaxis should be administered to women with any of the following risk factors: gestation <37 weeks, duration of membrane rupture >18 hours, or a temperature of >100.4° F (>38.0° C)."<sup>4</sup> This tragic outcome may have been avoided with relative ease and minor cost: by providing chemoprophylaxis at admission. Consequently, providers may want to consider providing chemoprophylaxis at admission if their patients' GBS results are not available, regardless of the presence of risk factors. Had this hospital had a policy of providing

chemoprophylaxis to all labor and delivery patients without GBS screening results, regardless of their risk profile, the baby might never have become infected.

## Risk Management Recommendations

The following risk management recommendations integrate the CDC GBS prevention guideline recommendations and basic risk management strategies for tracking test results.

- Screen all pregnant patients at 35 to 37 weeks gestation for vaginal and rectal GBS colonization.<sup>4</sup>
  - Document the screening date.
  - Educate patients about the reason for the screening.
    - If the patient refuses the screening, document the informed refusal discussion.
  - Tell patients approximately how long it will take to obtain results and request that they call the office by an appropriate date if they have not been advised of the results.
  - Have a reliable, fail-safe system in place to ensure that the GBS screening is done at the appropriate time.
    - If purchasing an electronic patient record in the near future, ask the vendor how GBS results are tracked.
    - Have a follow-up system in place that ensures that patients who miss screenings are contacted and educated as to the reasons for undergoing the screening and the risks associated with not being screened.
    - Ensure that follow-up efforts occur before the test's window of opportunity passes.
    - Establish policies that identify which office staff are responsible for the tracking of GBS results.
    - Document all follow-up efforts and their results.
- Order susceptibility testing for penicillin-allergic women.<sup>4</sup>
  - On the GBS screening specimen label, identify the patient as penicillin-allergic and specify that if GBS is isolated, it should be tested for susceptibility to clindamycin and erythromycin.<sup>4</sup>
- Have a system in place that tracks GBS screening results and that flags delayed results (a “tickler system”).
  - Proactively seek out and obtain the delayed results.
  - Document the follow-up and tracking of these results.
- When results are received (by mail, fax, email, etc.) by staff, make sure they route the results, with the patient's record, to a designated location for your review.
  - Once you have seen and initialed the results of the test, indicate the necessary follow-up by documenting the need in the patient's record.
  - Ensure that the patient has received all test results and recommendations for follow-up.<sup>4</sup>
    - Document patient notification of GBS screening result and, if it is positive, the recommended interventions.
- Confirm the delivery of the GBS screening and susceptibility results to the anticipated site of delivery.
- Ensure that the laboratory conducting GBS culturing is following CDC guidelines.
- At the time of labor or rupture of membranes give intrapartum chemoprophylaxis to all pregnant patients with GBS positive screening results.<sup>4</sup>
  - Patients with known negative GBS screening results obtained within five weeks of delivery do not require intrapartum chemoprophylaxis.<sup>4</sup>
- If a patient's GBS status is not known at the onset of labor, consider whether it may be appropriate to administer intrapartum chemoprophylaxis, regardless of the presence of risk factors.

# The Importance of Requesting Antibiotic Sensitivity

Due to the growing prevalence of clindamycin and erythromycin resistance, the need for obtaining culture sensitivities when ordering GBS testing for a penicillin-sensitive pregnant patient can not be understated. According to CDC and ACOG guidelines, penicillin is the agent of choice for intrapartum chemoprophylaxis. Ampicillin is an acceptable alternative. They further recommend cefazolin for penicillin-allergic women who are not high risk for anaphylaxis, and either clindamycin or erythromycin (depending on culture sensitivity) for women at high risk for anaphylaxis. Vancomycin (because of emerging vancomycin resistance) is recommended only when clindamycin and erythromycin are not options or when the susceptibility of a prenatal isolate is unknown. To facilitate consistent susceptibility ordering, the CDC and ACOG recommend that providers note on the specimen label when the patient is penicillin-allergic and specify that if GBS is isolated, the specimen should be tested for susceptibility to clindamycin and erythromycin.\*,†

## Resources

- \* American College of Obstetricians and Gynecologists. ACOG Committee Opinion: number 279, December 2002: prevention of early-onset group B streptococcal disease in newborns. *Obstet Gynecol.* 2002;100:1405-12.
- † Prevention of Perinatal Group B Streptococcal Disease: Revised Guidelines From CDC. *MMWR Recomm Rep* 2002; 51(RR-11):1-22. Available on the CDC web site at: [www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm) (accessed 10/14/2009).

## Additional Early-Onset GBS Resources

**CDC Group B Strep Prevention Web Site**  
[www.cdc.gov/groupbstrep/](http://www.cdc.gov/groupbstrep/) (accessed 10/14/2009).

Apgar B, Greenberg G, Yen G. **Prevention of Group B Streptococcal Disease in the Newborn.** *Am Fam Physician* 2005;71:903-10. Available on the AAFP Web site at: [www.aafp.org/afp/20050301/903.html](http://www.aafp.org/afp/20050301/903.html) (accessed 10/14/2009).

Powers RJ, Wirtschafter D, et al. **Prevention of Group B Streptococcus early-onset disease: a toolkit by the California Perinatal Quality Care Collaborative.** *Journal of Perinatology* 2009;1-11. Available on the California Perinatal Quality Care Collaborative Web site at: [www.cpqcc.org/quality\\_improvement/qi\\_toolkits/prevention\\_of\\_perinatal\\_group\\_b\\_streptococcus\\_disease\\_toolkit\\_rev\\_august\\_2008](http://www.cpqcc.org/quality_improvement/qi_toolkits/prevention_of_perinatal_group_b_streptococcus_disease_toolkit_rev_august_2008) (accessed 10/14/2009).

# GBS Rapid Result Screening and Vaccines

Commentators acknowledge the limitations of current GBS prevention efforts and highlight the need for GBS rapid-result screening and GBS vaccines. A rapid-result screen would reduce the risk that a woman has been colonized with GBS after she has undergone the recommended screening at 35 to 37 weeks; could be used where the woman's GBS results were not available; and could decrease the percentage of false-negative results attributable to defective lab processes and communication deficits. Real-time Polymerase Chain Reaction (PCR) tests are currently available, which would allow for screening women for GBS when admitted for labor and delivery, but the feasibility of using these tests has not yet been assessed.\*,†

## GBS Vaccines

Numerous Phase I and Phase II GBS vaccine studies have been conducted. However, before a vaccine could be ready for distribution, it would have to go through Phase III testing, which would necessitate the inclusion of a large number of pregnant patients. As the risks of GBS infection are relatively low and fetal safety cannot be guaranteed, some experts have concluded that regulatory and liability challenges will prevent the further development of a GBS vaccine.<sup>1</sup> Despite these challenges, a new study out of the University of Pittsburgh has shown that an investigational GBS III-TT vaccine was safe and elicited a “robust and sustained specific IgG response and significantly delayed the acquisition of vaginal and rectal GBS III.” ‡

### Resources

- \* Van Dyke MK, et al. Evaluation of Universal Antenatal Screening for Group B Streptococcus. *N Engl J Med* 2009;360:2626-36.
- † Powers RJ, Wirtschafer D, et al. Prevention of Group B Streptococcus early-onset disease: a toolkit by the California Perinatal Quality Care Collaborative. *Journal of Perinatology* 2009;1-11.
- ‡ Women receiving group B streptococcus serotype III tetanus toxoid (GBS III-TT) vaccine have reduced vaginal and rectal acquisition of GBS type III<sup>1</sup> IDSA 2009; Abstract 186.

## Conclusion

The feasibility of further decreasing the incidence of early-onset GBS depends on the ability to reduce the number of missed prevention opportunities.

Providers are encouraged to focus on closing the gaps that currently exist in GBS prevention by using the risk-management recommendations discussed above.

### Endnotes

- 1 Van Dyke MK, et al. Evaluation of Universal Antenatal Screening for Group B Streptococcus. *N Engl J Med* 2009;360:2626-36.
- 2 American College of Obstetricians and Gynecologists. ACOG Committee Opinion: number 279, December 2002: prevention of early-onset group B streptococcal disease in newborns. *Obstet Gynecol.* 2002;100:1405-12.
- 3 American Academy of Pediatrics. Practice Guideline Endorsement. Prevention of Perinatal Group B Streptococcal Disease: Revised Guidelines from CDC. Available on the AAP website at: [http://aapolicy.aapublications.org/misc/Prevention\\_of\\_Perinatal\\_Group\\_B.ddl](http://aapolicy.aapublications.org/misc/Prevention_of_Perinatal_Group_B.ddl) (accessed 10/14/2009)
- 4 Prevention of Perinatal Group B Streptococcal Disease: Revised Guidelines From CDC. *MMWR Recomm Rep* 2002; 51(RR-11):1-22. Available on the CDC web site at: [www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm) (accessed 10/14/2009).
- 5 Trends in Perinatal Group B Streptococcal Disease—United States, 2000—2006. *MMWR* 2009; 58(05):109-112. Available on the CDC website at: [www.cdc.gov/mmwr/preview/mmwrhtml/mm5805a2.htm?s\\_cid=mm5805a2\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5805a2.htm?s_cid=mm5805a2_e)
- 6 Powers RJ, Wirtschafer D, et al. Prevention of Group B Streptococcus early-onset disease: a toolkit by the California Perinatal Quality Care Collaborative. *Journal of Perinatology* 2009;1-11. Available on the California Perinatal Quality Care Collaborative Web site at: [www.cpqcc.org/quality\\_improvement/qi\\_toolkits/prevention\\_of\\_perinatal\\_group\\_b\\_streptococcus\\_disease\\_toolkit\\_rev\\_august\\_2008](http://www.cpqcc.org/quality_improvement/qi_toolkits/prevention_of_perinatal_group_b_streptococcus_disease_toolkit_rev_august_2008) (accessed 10/14/2009).

# Health Literacy – Discussing GBS Screening with Patients

“Health literacy” is the ability to understand and integrate health information to make appropriate healthcare decisions.\* Nearly half of all American adults—90 million people—have difficulty understanding and acting upon health information.† Patients with a reading level below the ninth grade are considered to be within the patient population with deficits in health literacy. Because most patient information is written at a higher grade level, these patients will struggle with most written patient materials. When a patient is pregnant, adequate communication between her and her provider is vital. Unfortunately, low health literacy can create a significant communication barrier between provider and patient.

Studies indicate patients with low health literacy are more likely to demonstrate inadequate understanding of prenatal screening tests than women with adequate health literacy.‡ A patient's comprehension of her prenatal screening/testing options cannot be assumed. Studies have indicated that assessment of health literacy is typically not performed by providers and, further, that providers are likely to overestimate a patient's level of health literacy.§ Assessing each patient's health literacy gives providers an opportunity to utilize interventions and instruments that can optimize the patient's medical decision-making capacity. Basic health literacy strategies can be employed by providers, such as:

- Speak slowly and spend a small amount of additional time with each patient, using plain, nonmedical language.
- Show or draw pictures.
- Limit the amount of information provided to pertinent tasks at hand.
- Repeat information.
- Confirm the patient's comprehension by asking him/her to repeat back aspects of what has been presented.
- Create a shame-free environment by making patients feel comfortable asking questions.
- Enlist the assistance of others (patient's family, friends) to promote understanding.∞

There are a variety of health literacy resources available to providers who treat pregnant patients. For example, the What to Expect Foundation's Baby Basics Program is a comprehensive prenatal health literacy program that teaches healthcare providers and educators how to use health literacy strategies to effectively communicate with pregnant patients. More information on the Baby Basics Program can be accessed on the foundation's Web site at: [www1.whattoexpect.org](http://www1.whattoexpect.org) (accessed 10/13/2009).

## Resources

\* American Medical Association Council on Scientific Affairs. Health literacy. *JAMA*. 1999;281:552–7.

† Institute of Medicine (IOM). Health Literacy: A Prescription to End Confusion, Report Brief. Available on the IOM Web site at <http://www.iom.edu/Reports/2004/Health-Literacy-A-Prescription-to-End-Confusion.aspx> (accessed 10/14/2009).

‡ Cho, et al. Health literacy and patient understanding of screening tests for aneuploidy and neural tube defects. *Prenatal Diagnosis*. 2007;27(5):263-7.

§ Lindau ST, Sharp LK. Detecting Low Literacy in the Clinical Setting: The Five-Second Screen. *Annals of Behavioral Medicine*. 2002;24S:S139.

∞ Weiss BD. American Medical Association Foundation and American Medical Association. *Health Literacy: A Manual for Clinicians*, 2003. (Table 13, Page 27).

# Risk Management Recommendations Related to the H1N1 Flu

With the potential for adverse patient outcomes as a result of this virulent strain of influenza, it is crucial that you adhere to good risk-management practices that promote patient safety and minimize liability risks, especially as these practices are aimed at preventing delays in diagnosis and accusations of negligent treatment of H1N1.

**Consider the following risk issues when caring for patients with flu-like symptoms:**

## **I. Telephone Liability**

- Train staff to screen calls appropriately.
- Be sure that appropriate screening occurs so that such patients are identified and referred to the physician, especially high-risk patients (e.g., pregnant or respiratory-compromised patients).
- Ensure that unlicensed staff members do not practice beyond their scope of service in handling calls.
- Have guidelines in place for screening calls.
- Ensure that all calls, including after-hours calls, are documented, including patient evaluation and advice provided.
- Ensure that on-call physicians handling after-hours calls follow up with primary care physicians (PCPs) and communicate the content of patient calls to appropriate PCPs.

## **II. Continuity of Care**

- Ensure that patients with flu-like symptoms (especially high-risk patients) are accommodated with timely appointments and follow-up.
- To minimize exposure, consider methods of separating such patients from other patients in the waiting room. Perhaps they can be taken to an exam room to wait rather than remaining in the waiting room.
- Ensure there is a follow-up system to track test and lab results.
- Provide timely follow-up for patients who need ongoing care to monitor symptoms and related medical conditions.
- Document all patient encounters (both in person and by telephone) and include patient evaluation, diagnosis and treatment.
- Maintain a high degree of suspicion for H1N1 flu, especially in the high-risk patient.
- Provide thorough patient education regarding treatment, follow-up care, and when to call or return to the physician. Document all patient education in the medical record.

## **III. Informed Consent/Refusal**

- Consider obtaining informed consent when administering the H1N1 vaccine, including a discussion of risks, benefits and potential complications.
- Obtain informed refusal when patients, especially those in high-risk groups, refuse the vaccine or your treatment recommendations.

*(continued on page 10)*

## Risk Management Recommendations Related to the H1N1 Flu

### **IV. Documentation of vaccine administration**

- In addition to documenting the vaccination in the patient's medical record, maintain a separate log for the patient's name, the vaccine manufacturer and the vaccine lot number in case of a vaccine recall or related problem.

### **V. Resources**

- If you have a limited supply of vaccine, refer to recommendations and guidelines from the CDC and state department of public health on prioritizing and administering the vaccine to those patients deemed in the highest risk groups. Updated H1N1 recommendations and guidelines can be accessed on the CDC Web site at: [www.cdc.gov/h1n1flu/](http://www.cdc.gov/h1n1flu/) (accessed 12/9/2009).

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**Target Audience:** Providers who treat pregnant patients.

### 1. Educational Outcomes:

Overall, degree to which the material presented is applicable in your practice setting:

Not applicable    1    2    3    4    5    Very applicable

### 2. Application of Risk Management Strategies:

To demonstrate your ability to apply or utilize the risk management recommendations herein, please rate the strategies you plan to implement or currently utilize in your practice (check your selection for each):

	Never	Seldom	Sometimes	Often	Frequently
Adhere to published standards and guidelines for the screening of pregnant patients for vaginal and rectal GBS colonization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Implement a follow-up system that ensures that patients who miss screenings are contacted and educated as to the reasons for undergoing the screening and the risks associated with not being screened.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Implement a follow-up system that tracks GBS screening results and that flags delayed results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inform patients about their GBS screening results and the recommended interventions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meticulously document the follow-up, tracking and communication of test results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adhere to published standards and guidelines for the management of known and unknown GBS screening results at the onset of labor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 3. Other Strategies to Minimize Risk

The medical professional liability risk management issues presented in this CME activity are communication, follow-up, documentation, informed consent and adherence to standards and protocols. Additional resources are available to help providers address these areas and reduce their risk exposure. For additional information, please contact the Risk Management Department at (800) 652-1051, ext. 2244.

### CME Attestation

I attest that I participated in this CME activity and claim \_\_\_\_\_ credits (use quarter hour increments) of *AMA PRA Category 1 Credit™* up to a maximum of one credit (hour).

Signature \_\_\_\_\_

Date (mm/dd/yy) \_\_\_\_\_

You may submit this form online at [www.norcalmutual.com/cme](http://www.norcalmutual.com/cme). Or you can mail or fax it to: Attention: Risk Management, NORCAL Mutual Insurance Company, 560 Davis Street, Suite 200, San Francisco, CA 94111, Fax: (415) 248-3301