mpie

RISK MANAGEMENT MANUAL

Liability Notice

This information is provided as a risk management resource and should not be construed as legal, compliance, technical or clinical advice. This information may refer to specific local regulatory or legal issues that may not be relevant to your organization. Consult your professional advisors or legal counsel for guidance on issues specific to your organization. Medical or clinical information presented is offered for educational and informational purposes only and does not replace independent professional judgment. The information is intended to provide guidance to the clinician in the management of patient care and is not intended to establish a standard of care. The clinician shall defer to applicable prevailing medical authority.

Contents of this manual do not supersede hospital policies and procedures as they related to employed providers.

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Welcome to the Michigan Professional Insurance Exchange

Company Overview

MPIE is structured as a reciprocal exchange and was formed in 1988; MPIE has been a trusted partner for healthcare providers and delivery systems since our formation. A reciprocal insurance exchange is an unincorporated association controlled by its members who are called subscribers. In a reciprocal, subscribers exchange contracts to insure risk among them. Each subscriber of the reciprocal is insured by each of the other subscribers. An Attorney in Fact represents the subscribers and is subject to the general supervision of the Board of Directors of MPIE, manages the affairs of MPIE.

The MPIE value and model allows the company to keep insurance rates as low as possible, while returning profits to subscribers not used for operations and claims payouts.

What Differentiates MPIE

- Customer service excellence
- Unparalleled financial stability
- Percentage return of premiums to eligible subscribers
- Competitive premiums
- 15% premium incentive for eligible subscribers
- Collaborative claims management and aggressive defense
- Proactive Litigation Stress Support and Resilience Program
- Targeted education focus on prevention/mitigation of high-risk issues

Provider Loss Prevention Program (PLPP)

MPIE leadership and our Board of Directors fully support a strong and progressive risk reduction and patient safety program. Physicians and advanced practice providers (APPs) insured with the Michigan Professional Insurance Exchange have an opportunity to attend and participate in cutting-edge patient safety/risk reduction activities. MPIE offers an unmatched premium incentive for participation in risk management education and activities - a maximum of 15% premium incentive may be earned.

Eligible MPIE subscribers include physicians and advanced practice providers (APPs). APPs are defined by MPIE as PA, NP, CRNA, and CNM. APPs earn the premium incentive toward their policy only and will not be accrued or double-counted with any other policy held by the physicians or corporation.

MPIE requires all subscribers to complete one risk management/patient safety activity every year in order to continue receiving their premium discount. The activity must be completed at least three (3) months prior to renewal. Failure to meet the education requirements will result in the loss of the premium discount for a full year. MPIE sponsors several educational events/seminars throughout the year and offers online educational activities that can be accessed at any time. Details are available on the MPIE website (www.mpie.org).

As a courtesy, MPIE emails notices to eligible providers at the beginning of their policy period notifying them that they are eligible to participate in the incentive program education requirement for that year. A reminder is sent to providers that haven't completed the requirement halfway through the policy period. Available activities to complete the requirement are included in the email notifications, posted on the MPIE website, and printed in the Facets newsletter. It is the sole responsibility of the provider to participate and ensure completion of the educational activity for the incentive program.

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Risk Management Services

MPIE provides the following risk management services for physician practices. Visit www.mpie.org for details. A member profile is required to access electronic resources. You can create a member profile or reset a forgotten password by clicking on the "Member Login" link at the top of the web page.

Educational Activities

Educational activities are offered in a variety of formats including live seminars, webinars, on-line courses, and videos. Offerings are customized to meet the client's need and offered for providers, office managers, front-line staff, and leadership.

Physician Office Practice Risk Management Manual

This manual offers guidance and tools on the most frequently asked risk management topics. It is located under the "Risk and Patient Safety" section of MPIE's website on the "Risk Reduction and Quality Improvement Resources" web page. The online version of this manual is updated regularly, we advise that practices utilize the online version to ensure the most up-to-date information.

Ambulatory Care Quality Improvement Manual

This manual provides guidance to apply the concepts of Plan, Do, Change, Act to any process in your organization that requires improvement. It is located under the "Risk and Patient Safety" section of MPIE's website on the "Risk Reduction and Quality Improvement Resources" web page.

Risk Management Self-Assessment Tool for Ambulatory Care Settings

The self-assessment tool provides practices with the ability to self-identify systems that may lead to patient harm or present a risk for litigation. It is located under the "Risk and Patient Safety" section of MPIE's website on the "Ambulatory Practice Safety Assessment Tools" web page.

Newsletters

MPIE publishes quarterly newsletters with information regarding risk reduction topics, upcoming events, and company updates. Electronic versions of newsletters are available at www.mpie.org under the Risk & Patient Safety section. Newsletters are sent by email to all insured physicians and office managers. Insured clients are automatically added to our newsletter distribution list.

E-News Alerts

MPIE sends email updates on emerging risk issues and risk reduction strategies titled E-Alerts. Also, MPIE partners with ECRI Institute to provide practice/office managers with a bi-weekly news service that covers a variety of office-based news including patient safety and risk management issues, legal and regulatory concerns, standards and guidelines, and medical device hazards and recalls. If you do not receive the newsletters or the ECRI news service please contact MPIE at risk@mpie.org or (616) 202-1997.

Web Resources

In addition to the resources above, links to a variety of authoritative websites, sample documents, and tools to assess your practice's level of compliance with regulations and patient safety practices can be found on MPIE's website. We've also compiled a list of answers to frequently asked questions. These resources may be found in the "Member Login" section at https://www.mpie.org/."

Telephone Consultations

MPIE provides telephone consultation for physicians and their office managers. Questions concerning risk management issues and how to respond to legal notices frequently arise. Answers to several commonly asked questions are listed on the MPIE website at www.mpie.org under the Member Login section. If a question requires the involvement of legal counsel, MPIE will assist our practices to access this expertise. If you have a risk management situation or question that may benefit from a consultation, please contact MPIE at (616) 202-1997.

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Giving Assistance to Patient and Providers (GAPP)

What is the GAPP Program?
MPIE's Giving Assistance to Patients and Providers ("GAPP") Program is an innovative opportunity for physicians to participate in a structured patient-centered approach for addressing complications associated with medical care and treatment while focusing on preserving the physician-patient relationship.

Program Goals
The goal of the GAPP Program is to provide the patient with prompt, attentive care, support, and assistance so the patient's full focus can be on recovery. The GAPP Program was designed to meet patient recovery needs and resolve their concerns. At the same time, the program assists the physician with managing patient perception regarding the outcome of their care and assists with disclosure if appropriate. The result is an enhanced physician-patient relationship and a caring environment that fosters the patient's recovery.

How does the program work?
The treating physician must refer a patient to the program to initiate the process. If the unanticipated outcome/known complication qualifies for the program, the physician then has a discussion with the patient about the unexpected outcome and the GAPP Program. MPIE will work with the patient directly on the financial aspect and handle reimbursement or payment of out-of-pocket expenses as determined.

Program benefits for your patient

- Assist the provider with providing an explanation of the unexpected outcome, show empathy, and/or an apology (if appropriate)
- Provide reimbursement for medical & non-medical needs not covered by insurance
- Provide reimbursement for additional time off work as a result of the event

For more information regarding the GAPP Program, please see the GAPP Program Brochure.

Contact MPIE's Claims Department at claimintake@mpie.org or call (616) 202-1799 to participate in this program.

Litigation Stress and Resilience Support Program

MPIE provides a Litigation Stress and Resilience Support Program to proactively support our physicians and advanced practice providers.

MPIE will offer the provider an option to speak to a peer physician supporter (retired/ seasoned physicians) or a professional resilience counselor about the effect litigation has on them personally, professionally, and what they may expect during the litigation process. This service is not intended to discuss any part of the care involved in the claim but rather the emotional perspective and coping strategies.

MPIE physicians/providers involved in malpractice litigation may receive proactive telephone calls from a litigation resilience counselor at critical junctures during the litigation process as follows:

- Initial suit or notice of a catastrophic event,
- Time of deposition,
- Trial or settlement,
- At any time during the litigation process when the physician exhibits stress related behaviors.

The purpose of this contact is to provide encouragement and assistance navigating the litigation process and dealing with the emotional toll it can take. Those that have engaged in these conversations have benefited as follows:

- Decreased sense of isolation and negative thoughts
- Increased ability to cope with stress
- Lessened feelings of fear of additional lawsuits
- Maintain their focus on the practice of medicine

Physicians/providers should expect these calls as part of our claim management process. They are intended to ensure the highest level of provider support we can provide during the life of a malpractice claim.

Physicians and advanced practice providers can also access our support services at any time by contacting MPIE at (616) 202.2288. The provider will promptly be connected with a litigation stress or peer supporter depending on their choice and the supporter's availability.

Introduction to Risk Management & Patient Safety

The Risk Management Manual was created to guide providers and their practice managers on a variety of topics and situations that are either frequently encountered, potentially high risk for litigation, or a risk to patient safety in the physician practice setting. Traditionally, the role of risk management was seen only as loss control; there to minimize and, when possible, prevent the potential for loss (litigation). Risk management's purpose has evolved to include and focus on prevention techniques that center on the safety and quality of the patient's care and treatment. MPIE fully embraces this expanded role and focuses on teaching and activities that promote the patient safety aspect of protection for physicians. We strongly believe that through promoting patient safety practices the potential for litigation decreases.

Risk management in the office setting should focus on the following:

- Communication
- Direct patient care activities with the potential for liability
- Office policies and procedures

#1: Communication

Greeting Patients

The first few moments of a medical encounter are critical to establishing rapport, making the patient feel comfortable, and setting the tone of the interview. Accordingly, widely used models for teaching and assessing communication skills highlight the importance of greeting patients appropriately. Healthcare providers are encouraged to address the patient by his/her preferred name introduce himself/herself and explain his/her role in the medical encounter. Appropriate greetings by a healthcare professional build a loyal relationship with patients and studies show that loyal patients are less likely to bring a suit in the event of a medical error.

Using SBAR Techniques in Communication

SBAR is a standardized way of communicating. It promotes patient safety because it helps individuals communicate with each other with a shared set of expectations. Staff and physicians can use SBAR to share patient information in a concise and structured format. It improves efficiency and accuracy.

SBAR stands for:

- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendation

Here is an example of a call to a physician using SBAR:

Introduction

- *Dr. Jones, this is Katie Mulder RN, I am calling from ABC Hospital about your patient Eva Smith.*

Situation

- *Here's the situation: Mrs. Smith is having increasing dyspnea and is complaining of chest pain.*

Background

- *The supporting background information is that she had a total knee replacement two days ago. About two hours ago she began complaining of chest pain. Her pulse is 120, and her blood pressure is 128/54. She is restless and short of breath.*

Assessment

- *My assessment of the situation is that she may be having a cardiac event or a pulmonary embolism.*

Recommendation

- *I recommend that she be seen by…*

Resource: IHI SBAR Tool

Primary Care and Specialist Communication

Transition to the electronic medical record (EMR) facilitates more dynamic and timely provider communication. Although communication has improved, gaps may still occur between primary care and specialty providers and at the transition of care junctures, leading to patient injury. Collaboration among providers consists of ensuring clear communication through the use of both verbal and written forms of communication. In the practice setting, management of a patient's care depends on effective communication between the various parties involved in the patient's care. Phones, faxes, emails, and written reports are methods used to accomplish this task. Some ground rules may include the development of order/referral forms with checkboxes for the ordering physician to use when referring a patient to a specialist. Checkboxes ensure that all the required information that the specialist would need is filled out on the paper/electronic form. Regarding paper forms, - maintain a copy of

the paper form in the medical record and send another to the specialist.

Problems arise when patients return to their primary care physician for assistance with decision making or next step considerations in their treatment, and the primary care physician has not received the specialist's report. The primary care physician then lacks the necessary information to assist their patient or is scrambling to get the report while the patient waits. The patient and physician are both frustrated with the unproductive use of time. The specialist, too, may create a form to easily communicate back to the referring provider. The form would indicate the next steps, such as treatment or testing that could be filled out with the patient in the room, so the patient is aware of their next steps and then sent to the referring provider.

Suggestions for physician to physician collaboration:

Referring providers:

- When possible, speak personally with the consultant before the patient visit with the specialist.
- Educate the patient on the rationale for the referral. Patients who participate in their medical decision-making report higher levels of satisfaction with their care and are more likely to adhere to medical recommendations.
- Adopt a standardized format for ordering consults. Examples of standard medical information to provide includes: relevant patient history, working diagnosis, what tests/diagnostic studies should have been performed (and results of said studies when applicable), and current medications.
- Ensure that communication to the specialist includes clear direction of the desired outcome for the patient. For example, if the referral is for information and direction, state that versus a referral for the specialist to assume care.
- Be clear on what questions need to be answered by the specialist and the expected timeline (urgent versus routine).
- Keep track of referrals. If using a manual system, incorporate the use of a log sheet to facilitate tracking.

Consulting physicians: Specialist

- Respond to all referrals in a timely fashion. If unable to provide the necessary services requested, clearly communicate such back to the referring provider.
- Determine which provider will assume responsibility for follow-up and communication to the patient.
- Avoid inflammatory remarks (both verbal and written) regarding previous treatment and care.

What to do when conflicts occur

If the primary care provider finds that the specialist is not providing the necessary

information, or not providing timely updates, there must be clear communication between the provider and specialist. A straight-forward and diplomatic is the best approach to resolving this conflict and ensuring the best outcome for the patient. It is suggested that the provider call the specialist directly and have a conversation explaining the challenge and communication gap.

Have potential solutions in mind such as: suggesting that chart notes or reports be faxed to the office or suggest that a staff member of the specialist office call the referring office and verbally communicate findings. This allows for timely feedback from the specialist of the initial impression and treatment options.

Resource: Leveraging Provider Communication for Better Care Coordination

The EMR alleviated many of the communication challenges between providers. Michigan Medicine has several options for a referring physician to access their patients' electronic medical records, including:

- Michigan Medicine Provider Portal
- Great Lakes Health Connect
- Care Everywhere (Epic facilities only)
- Direct Messaging

Resource: Electronic Medical Records Access

Hallway Consults

For multi-provider practices, occasionally an informal request for advice from one provider to another are appropriate and helpful but also poses a risk for both providers.

If you are requesting information:

- This is not a formal consult so any advice or input received must be evaluated for accuracy
- Unless making a formal consult, do not include the name of the consulting provider in the patient's medical record
- When the care is complex, request a formal consult and document in the patient's medical record

If you are the informal consultant:

- Reiterate that all pertinent patient information is unknown so any recommendation could be incomplete or inaccurate
- Request a formal consult

Electronic Communications

Email, text, or other forms of electronic communications while becoming very popular are fraught with potential liability and confidentiality breach risks. Extreme care and caution are recommended if the practice is considering or currently allows this form of communication with patients outside of secure, patient/provider portals.

The practice should develop policies and procedures for the use of electronic communication as they may provide a basis for a defense in confidentiality breach charges. Emails are subject to discovery in medical malpractices and providers must be aware that generally, Professional Liability Coverage does not cover litigation related to breaches of confidentiality and their associated fines.

Develop a policy regarding email, specifying uses and limits and permissible content. Sample items to include in policies and procedures may include:

- Review HIPAA Security Standards to ensure that electronic communications are secure and protected - The Security Rule.

Adhere to all HIPAA guidelines. Guidelines require encryption for all email which transmits protected health information.

- Use e-mail communication only with established patients.
- Refrain from providing abnormal or unexpected test results via email.
- Educate patients who elect to use email about the physician practice email policies. Require patients to sign an email consent form. The consent form should include when the use of email is appropriate (e.g., not appropriate for use in an emergency).
- Automatic reply to all incoming messages is helpful. Sample wording may include, “Your message has been received by [practice name]. We will attempt to process your request within one business day. If you need immediate assistance, please call [phone number].
- **All email regarding patient care should be filed in the patient’s medical record.**
- A designated staff member should be responsible for checking and routing all incoming emails in a timely fashion and in accordance with office policy. A back-up staff member should be identified
- Validate the “send to” field before sending the email. Include a banner that states, “This is a confidential medical communication” at the beginning of the message.

For an expanded and more complete list, please see the AMA resource listed below.

Resource: AMA Guidelines for Physician-Patient Electronic Communications

Telephone Communications

Often, the first outpatient contact a patient has with the medical facility is by telephone. Staff should be instructed to answer the phone politely, pleasantly and expediently. The diction, pitch, and clarity of the person answering influence a telephone caller's first impression of a physician's office.

- Diction - proper pronunciation of words to allow others to understand clearly.
- Pitch - refers to the sound of the medical assistant's voice. May be low and deep or high and squeaky. It is always important to create a pleasing tone for the patient to be comfortable.
- Clarity - being easy to hear with coherence and intelligibility.

Telephone etiquette also increases patient satisfaction. Each call should be answered with the physician's or practice name and the receptionist's name, for example: "Dr. Jones' office, Chris speaking. How may I help you?" Most callers find an impersonal response unpleasant and unprofessional. The telephone answerer should always ask permission before placing a caller on hold. The average time any caller is left on hold should be less than 2 minutes, or permission asked of by the patient to continue to hold.

A communication problem can occur when well-meaning staff who take incoming calls acts as a barrier between patient and doctor. When relying on staff to manage patient access to the physician, the primary goal needs to be accessible. Otherwise, the physician may be exposed to risk because he/she was not alerted to a situation that demanded immediate attention. A system for screening and triaging telephone calls should be established so that calls requiring a direct response are forwarded to the physician.

A telephone priority list should be prepared. The following categories are appropriate:

- Must get through to the doctor immediately.
- Must interrupt the doctor for evaluation and instructions.
- A doctor will return the call within one hour.
- The call can be transferred to the clinical staff.
- The practice manager will return the call.
- Hold for the doctor's instructions.
- A receptionist may handle.

The office procedure manual should list the categories with examples of calls assigned to each category (see Telephone Triage section of this manual). The manual will educate new employees before they begin, and it will help assure consistency in the way calls are handled. Additional guidelines should specify the information staff must obtain from the patient so an accurate medical assessment can be made. If a caller prefers not to give personal information to staff, his/her

preference should be honored. On the telephone, as in all aspects of the patient's care, guarding confidentiality is imperative. Every incoming patient telephone call requesting medical information or reporting data must be documented in the patient's medical record.
Maintain appropriate telephone logs with entries written in ink. Keep old telephone logs for the same duration as patient medical records are maintained.
The caller's name, telephone number, the date and time of the call, the person who spoke with the caller, the reason for the call, and the action taken should all be recorded.

The office should have a process for making medical records available to the physician when talking with the patient by telephone. Thorough documentation in the medical record of telephone conversations between the physician and patient or the office staff and patient is essential, with particular attention to any instructions given to the patient. This responsibility extends beyond regular office hours. **All after-hours telephone calls to the physician should be documented and placed in the patient's medical record the following business day.** In a group practice, provisions should be made for notifying the patient's primary care physician of any instructions or medications given.

Standardized forms can be used to document after-hours telephone conversations.

Answering Service

Every physician practice must provide patients with a method to reach them after hours. Contact may be accomplished with an outgoing only message that contains the on-call physician's contact number for patients to call directly or it can be a live answering service. The preferred method is an answering service, simply because this service can provide third-party evidence of timely response to incoming patient calls in the event a claim arises.

Minimizing risks:

- **Identification as the Answering Service.** The answering service's operators should tell callers they are speaking to the answering service and not to the physician's office.
- **Provide Instructions.** The answering service should have instructions from the physician about callers and what to tell them if they have an emergency. Such as asking each patient if this is an emergency and advising patients to call 911 or go to the hospital if they feel they cannot wait for the physician's return call.
- **Unauthorized Advice.** Diagnosing and prescribing fall outside of the scope of the telephone operator. Never allow the operators to diagnose or prescribe

medications or treatment.

- **Complete Contact Information.** Make sure the service knows whom to contact and how to reach that person. Include all contact information and for what period call is active.
- **Be Available.** Ensure the on-call physician is available. Provide the answering service with an emergency number in the event that the provider on call cannot be reached.

Morning Reports. Establish a reporting schedule for overnight and weekend calls to ensure timely follow-up.

- Documentation of Calls. It cannot be emphasized strongly enough that all clinically significant after-hours calls must be recorded. The failure to record after hour's calls is the most common area cited as missing in physician medical record reviews. Use standardized recording templates. Be certain to timely enter the notes in the medical record. Include the patient's name and complaint, the advice given, the date and time the call was received, and, most importantly, when it was returned. The physician will be required to defend their standard of care based on the expectation that a reasonable physician would have reached the patient in the same time frame with similar advice.

The answering service is an extension of the practice and should be treated as such. Therefore, it is recommended that the service be scrutinized: pose as a patient and call the service to check efficiency and accuracy. If not satisfied, file a complaint or contract with a different service.

Resource: Avoiding Negligence and Malpractice While On Call: Guidelines for Physicians

Telephone Triage

Telephone triage training for staff should include a list of questions to ask the caller/patient and instructions for when to immediately refer the call to the physician. Document all calls involving a patient or family member. Documentation should include the date, time, and patient name, name of caller/relationship to the patient, complaint, and advice given. Establish a reasonable time frame in which non-urgent calls are expected to be returned and if possible, build time into the physician's schedule to return calls. Always inform patients when they can expect a return call and periodically review telephone procedures and protocols with staff to ensure that telephone encounters are being appropriately managed.

Resource: Sample Telephone Triage/Decision Guide

Office Brochure

The development of a brochure for the practice provides new and existing patients with the necessary information to familiarize them with the practice. Often, surprises in health care are unpleasant for patients, and a practice brochure may help eliminate at least some of those surprises. Suggested topics to include in a practice brochure are:

- Office hours,
- practitioner information,
- telephone calls,
- after-hours and emergency care and
- billing procedures.

Consider including a statement advising patients that when they are admitted to the hospital, their primary medical care may be managed by a partner of the practice or a hospital-employed Hospitalist.

An office brochure details what services will be provided to patients and what is expected from them in return. It can be plain and inexpensively typed on office stationery or professionally printed.

Many practices now have websites that act as their practice brochure. If the practice relies on a website to communicate with patients ensure that patients are directed to it verbally and in writing (on business cards, appointment reminder cards, and in letters).

There is a wide selection of free medical office practice brochure templates online.

Advance Directives

Adult patients have the right to have an advance medical directive (such as a durable power of attorney for health care or living will) concerning treatment or to designate a surrogate decision-maker. The expectation by patients that the physician/hospital will honor the intent of that directive to the extent permitted by law. The physician or their staff should advise patients of their rights under state law to make informed medical choices, ask if the patient has an advance directive, and include that information in the patient medical records. If appropriate, the patient should have a Do Not Resuscitate (DNR) or DNR Comfort Care-Arrest (DNRCC-A or DNRCC-Arrest) order in their medical records with a time frame in which the order is to be adhered to. The DNR should be noted in a prominent place in the medical record.

Incapacity can come as the result of unanticipated illness or accident as well as the aging process. Discussions about Advance Directives can become part of a practice's normal conversation with new adult patients and at annual physicals.

Patients who have these documents can update them at any time and may choose to revoke them, so it is also appropriate for the practice to update their file information regarding the patient's Advance Directive at least annually.

Resource to Advance Directives - State of Michigan https://www.michigan.gov/documents/miseniors/Advance_Directives_230752_7.pdf

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#2: Consent

This chapter in a nutshell:

The liability or risk to the physician: Allegation of a lack of informed consent. According to the Joint Commission, informed consent is an agreement or permission accompanied by a full notice about the care, treatment, or service that is the subject of the consent (2016).

Risk Prevention Strategies:

- Documentation = Consent form and discussion note in medical record
- Discussion = Done in the office setting and done by the physician

Purpose and value of informed consent

A properly developed, patient-signed consent form is compelling evidence that a patient was adequately informed before a medical procedure. Informed consent to medical treatment is essential when it comes to ethics and law. It can deter litigation or at least help the physician prevail in the courtroom setting. Informed consent also encourages a patient to be more responsive to advise and is associated with a patient's ability to recuperate more quickly, require fewer analgesics, and feel less anxiety-while experiencing few complications and days in the hospital. Informed consent allows a patient to make a sound decision based on the information that has been provided to them by their provider.

An adequate informed consent process includes not only the dialogue with the patient or other decision-maker but also the documentation of the discussion and the patient's understanding of the information communicated. It is the standard process to document the informed consent discussion in the office progress notes as well as employ a procedure-specific, patient-signed consent form.

It is advised that the in-office consent documentation is sent to the hospital for surgical procedures.The provider needs to confirm that the patient understands the information that is being provided to them and also understands the benefits and the risks. Some barriers during the informed consent process include a lack of basic information on the consent form, lack of communication between the provider and the patient, health literacy, and cultural issues. It is recommended that providers use the teach-back method to determine that the patient understands the risks and benefits of the proposed treatment recommended by the provider.
Failure to provide patients with sufficient information for an informed consent places a physician at risk for a medical malpractice claim for an injury from a complication or unanticipated outcome of the procedure – even if it was not the result of negligence.

Resource: Making Informed Consent an Informed Choice: Training for Health Care Professionals Audio Script

Documentation of consent

Documentation of informed consent is essential when it comes to providing proof if a malpractice suit arises. The informed consent process is documented in two separate ways in the medical record. The first way is by obtaining the patient's signature on an appropriate **consent form** following the necessary disclosure of information upon which a patient can give his or her informed consent. Informed consent is more than just a signature. The provider should make sure that everything on the consent form has been explained to the patient or medical decision-maker. The patient signature confirms that they agree and are comfortable with going through the treatment specified by the provider. The second way is documenting the informed consent discussion in the patient's medical record. This documentation can be an entry in the office medical records maintained by a physician or by documentation in a progress note in the hospital record. It is preferred for hospital surgical procedures that the consent process is done in the surgeon's office in advance of the procedure. Doing so enhances the patient's understanding of the procedure because it is done at a time of lower patient anxiety and encourages patients to ask more questions. It also leads to a more thorough informed consent process, providing a strong deterrent and defense in the event of an alleged lack of informed consent.

Who should obtain consent?

A frequently asked question is whose responsibility is it to obtain consent from the patient? The basic rule of thumb is that the duty to disclose pertinent information resides with the caregiver who is to perform the diagnostic test, medical care, or surgery. (243 CMR §3.10:1 (c) (2012)) Rozovsky explains this in Consent to

Treatment- A Practical Guide as, only those who have the necessary relationship to the patient, should be obliged to disclose pertinent information. For example, in the diagnostic setting, the person carrying out the invasive test is obligated to obtain consent. The PCP may refer the patient for a mammogram, but the radiology technician must secure the patient's actual consent. In the surgeon's office, it would be the surgeon who would have the necessary relationship and pertinent information for obtaining consent.

What is often confused is who can obtain the necessary signatures and paperwork completion. In some practices, so long as obtaining the signed consent is no more than an administrative function that reduces to paper the fact that the patient has agreed to specific procedures, this function may be assigned to clerical staff. **The actual consent discussion process (risks/benefits/alternatives) remains solely with the surgeon, in this example.**

The Agency for Healthcare Research and Quality (AHRQ) defines shared decision-making as a process involving the clinician and the patient in which the patient:

- understands the risk or seriousness of the disease or condition to be prevented
- understands the preventative service, including the risks, benefits, alternatives, and uncertainties
- has weighted his or her values regarding the potential benefits and harms associated with the service
- has engaged in decision making at a level at which he or she desires and feels comfortable

Resource: The SHARE approach- Essential Steps of Shared Decision-making: Quick Reference Guide

Including patients and their families in the part of their own health treatment plan decisions can empower them and keeps the patient engaged in their care. Each practice should incorporate basic shared decision-making communication techniques. In shared decision-making and informed consent, the patient is provided information, sometimes through visual aids along with discussions with the provider. The decision made in informed consent should be a process, shared with the patient and physician.

Visual aids

Videotapes, charts, and diagrams can enhance a patient's understanding of the procedure, prompt questions and increase the likelihood that the patient will remember the discussion. These same visual aids also make for good defensible medicine. Few jurors are likely to conclude a patient was not adequately informed

when the very same videotape, diagram, or chart that was shown to the patient is used during the trial to explain the procedure clearly to the jury. As resources are updated, previous versions should also be maintained. Of course, care should be taken to be sure the patient understands the results depicted within the audiovisual material, which may be achieved by asking the patient questions about their understanding and documenting it in the medical record.

Audiovisual materials do have their limitations. Audiovisual materials are an adjunct to the informed consent discussion. They are an aid to achieving a meeting of the minds between patient and physician. They are not a substitute for face-to-face discussions with the patient. The audiovisual materials often stimulate questions, which, together with the physician's answers, allow the patient to make an informed decision about the treatment or procedure. The fact that the patient was provided the education should be documented in the medical record. Document in the medical record what educational brochures/diets/printed instructions were given to the patient/family as well as the name of the videotape viewed. Also, include that you provided the opportunity for further questions and discussed their ability to repeat to you the instructions and information.

Resource: The Ottawa Personal Decision Guide (OPDG) is designed for any health-related or social decision. It can help people assess their decision-making needs, plan the next steps, and track their progress in decision making.

Information: http://decisionaid.ohri.ca/
Interactive Guide: http://decisionaid.ohri.ca/docs/das/OPDG.pdf

Informed Refusal

Informed refusal is when a person can be said to have given the refusal to an intervention based upon an understanding of the facts and of the implications of not following a recommended diagnostic or therapeutic action. Informed refusal is linked to the informed consent process, as a patient has a right to consent, but also may choose to refuse. The individual needs to have the relevant facts as well as their reasoning faculties.

Informed refusal has these four components:

- The doctor determines the patient needs a particular operation, test, medication, or other type of medical intervention.
- The doctor tells the patient about the needed intervention.
- The patient refuses the recommended treatment for any reason: "I don't think I need that test." "I don't like needles." "I don't care if I die."
- The doctor must explain the risks of not having the treatment, so the patient can make an informed decision when refusing it.

The following information should be discussed with the patient and documented in the medical record:

- The nature of the patient's illness, the diagnosis, the proposed treatment plan, and the prognosis.
- A description of the recommended procedure or treatment, and its purpose.
- The probable outcome particularly if it is difficult to predict, and the patient's expected post-procedure/treatment course.
- The most likely risks and side-effects, the potential benefits, as well as the possible complications of the procedure or treatment.
- Reasonable alternative methods of treatment or non-treatment including the risks, benefits, complications, and prognosis associated with each alternative or with non-treatment.

A physician will want to document the patient refusal to recommended treatment. Documentation of refusal to treatment is key to minimizing your risk exposure if something is to happen to the patient in the future. In electronic medical records, a refusal form may be used and scanned into the record.

Resource: Sample Informed Refusal Form

Informed Consent & Minors

A minor is any person under the age of 18. Generally, minors may not consent to medical treatment on their behalf without the approval of a parent or guardian. There are several laws that authorize minors to be able to consent to certain types of medical treatment without parental consent. Medical treatment covered by these statutes includes:

- Pregnancy (MCL 333.9132),
- Contraception (Doe v Irwin)
- Sexually Transmitted Diseases and AIDS/HIV. (MCL 333.5127)
- Rape/Sexual Assault. (MCL 722.523)
- Mental Health. (MCL 330.1707)
    - *Outpatient Care – a minor age 14 or older may request and receive up to 12 outpatient sessions or four months of outpatient counseling.*
- Substance Abuse. (MCL 333.6121)

If a minor needs medical treatment and they have legal power, they are able to consent. For example, a minor can consent to treatment for the prevention and care of pregnancy, and the minor's parents have no knowledge of the proposed care, the physician will generally discuss with the minor the advantages of disclosing the proposed treatment to the minor's parents or guardian before services are rendered. The physician and minor should reach an understanding concerning 1) the extent to which the parents or guardians will be informed, 2) who is responsible for paying the

cost of the medical treatment, and 3) to whom the physician can disclose the medical information that is necessary to obtain payment for the treatment. Minors should understand that it may be impossible to keep the information from their parents if the minor expects the parents' health plan to pay for the services.

Resource: Michigan Laws Related to Right of a Minor to Obtain Health Care without Consent or Knowledge of Parents

Divorced Parents and Step-Parents

When parents are divorced, their respective rights and parental obligations are defined by the particular custody arrangement approved by the court. There are two primary types of custody: **Physical Custody** and **Legal Custody.**

- Physical custody means that the child resides with that parent and is under his or her primary supervision. However, physical custody is not always reflective of who has the legal authority to consent. For example, often the child lives solely with one parent as a matter of convenience, while both parents share authority (i.e., legal custody) and may jointly consent to their child's medical treatment.
- Legal custody means that a parent has the authority to make important decisions on behalf of the child, e.g., decisions relating to education, religious practice, and healthcare. In general, only parents with legal custody may consent to the child's medical care and treatment or authorize the release of the child's medical record to third parties. Legal custody may be awarded to one ("sole custody"), or both parents ("joint custody").
- A crucial first step to resolving custody conflicts is to clarify the legal custody arrangement. Since frustrated parents may misinterpret or even misrepresent the custody arrangement, it is prudent to request a copy of the court order relating to custody. This document details the rights and obligations of either parent and should be retained in the medical record. Mr. and Mrs. Smith should be asked to provide a copy of the custody order, ideally before any further discussion of treatment.
- If Mr. and Mrs. Smith have joint legal custody, either one, acting alone, may provide consent for the medical care and treatment of Sally. Although either parent may give consent independently, physicians are well-advised to try to obtain the consent of both parents, particularly if treatment presents a serious risk to the child or is objectionable for any reason. Although joint legal custody generally means parents have equal authority to consent, the court may require both parents to agree upon certain or all medical decisions made on behalf of the child.
- If either Mr. or Mrs. Smith has "sole legal custody," he or she is the sole decision-maker in matters relating to Sally's healthcare. If Mrs. Smith is

the sole legal custodian, Mr. Smith may not give (or withhold) consent for his child's treatment. However, under most circumstances, he is entitled to receive information about his child's medical treatment as well as a copy of the medical record, upon reasonable advance request. The treating physician, however, may choose to notify Mrs. Smith of Mr. Smith's request before releasing the record.

- What if Mr. and Mrs. Smith have joint legal custody but can't agree? In non-urgent situations, a physician would be well advised to step back and let the parents settle the disagreement. Although you are the child's advocate, you need not act as the mediator of an acrimonious custody dispute. Your responsibility lies in furnishing clear and comprehensive information regarding your treatment plan while providing an opportunity for questions and concerns. If a delay in treatment will cause risk for the child, document your explanation to the parents of risks that are inherent in the delay.
- If all else fails, recommend that parents seek the intervention of the court. However, if any delay in treatment would present harm to the child.
- From the start, determine with whom you're dealing. Try to identify custody arrangements early by having parents of new patients indicate their specific arrangement on your "New Patient Information Sheet." Specifically, ask "Are you married or divorced?" "Who has legal custody of the child?" and "Who has physical custody?" Periodically, ask parents if there have been any changes to the custody arrangement.
- Once you read the court order relating to custody, make sure that your office contact information accurately reflects the court order. Identify for your staff whether one, or both, parents (1) may give consent or (2) serve as the contact.

The Sample Delegation of Authority for a Minor form may assist the practice in providing necessary care to a minor without the biological parent present, by having provided authorization to another for medical care of their child.

Resources: Sample Delegation of Authority for a Minor

Clinical Trials

Some office practices chose to become involved in clinical trials. It is important that the trial chosen be appropriate for the practice and its patients. The practice's responsibility in these matters' paraphrases medication safety rules:

- right study
- right patient
- right consent

Sponsors of clinical trials provide informed consent forms for patients who agree to become involved in the study. These forms can be long and complex. The practice will carefully monitor the study along with any others who are charged with its supervision. Practice staff should understand that it is essential that patient confidentiality be maintained during and after the study. It is easy to get caught up in the research and the complexity of the process, but physicians can minimize their risk by focusing on the patient and patient safety. In the event of an adverse outcome, or outcomes, in the study, an investigation may determine:

- harm or injury suffered by the patient
- required treatment
- need for notification of appropriate agencies
- compensation, if appropriate, for injured patient

All phases of a clinical trial are carefully documented. The patient's medical record should also note that they are participating in a clinical trial, though the trial data is not recorded in the patient's medical record.

Mandatory Reporting to State Agencies

Physicians are required by law to report a variety of diseases and conditions. Keeping up with what is to be reported, to what agency, in what way, and under what conditions may seem a bit daunting. The state has provided written materials and online resources to aid in these responsibilities. Health care professionals are advised to consult with their local health department if they have questions about their responsibilities.

Resources: Michigan's Communicable Disease Rules

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Proper Documentation

The medical record is a complete record of a patient's medical history, medical care, and other pertinent information that's relevant to the delivery of care, billing, and other purposes. The 'legal medical record' is a business record that encompasses the care that has been provided and other information the entity uses to perform business functions. The medical record is the primary means of communication among healthcare providers about a patient's medical history and course of care and treatment. Missing, incomplete, or illegible documentation can seriously impede patient care and the defense of a malpractice claim, even when care was appropriate.

Medical record documentation should 'tell the patient's story' and generally includes patient assessment, diagnosis, plan for treatment, interventions, and evaluation of the patient's response to treatment. Document patient education including the teaching method, the name of any materials that were provided to the patient to supplement verbal teaching, and the patient's response (e.g., repeat back, return demonstration). Document thoroughly in the medical record any discussions pertaining to informed consent and informed refusal for treatment. Mechanical errors such as inaccurate statements in factual information, errors in transcription or written orders, delayed or post-dated recordings, illegibility, incorrect methods used for documentation corrections, or adding an addendum may cast doubts about what was actually done for the patient, as well as when.

Alterations: Patient records should never be altered. Any changes to the medical record, whether electronic or paper, should be done according to the organization's established policy and procedures for correcting documentation. One should not erase, obliterate or attempt to edit notes previously written. All corrections, late entries, entries made out of time sequence, need an addendum marked as such in the record and must be dated and timed on the day they are written and signed. Clinicians should draw a single line through any erroneous chart entry and write "error" with the date and time, as well as their initials. Include the reason for the updated medical record documentation.

Charting Do's & Don'ts

Do chart:

- Objective findings through examination and review of pertinent medical information.

- The patient's next of kin or personal representative.
- The date and time seen, reason and location of each visit.
- The patient's personal and medical responses to services including non-compliance and/or failure to follow instructions.
- Informed consent or informed refusal discussions.
- History and physical findings.
- Past medical history, past surgeries, medication list, allergies and drug sensitivities.
- Specialist and consultant referrals, including the professional services rendered and their results.
- The presence of family or friends in an exam room during examination or treatment.
- The name and role/title of the office staff member who served as the chaperone for the patient examination, when applicable.
- New diagnoses, changes in condition, and the addition or termination of medications and treatments.
- Specimens obtained and tests ordered, including when and where they were sent, the patient's status following any procedures, and test results.
- Patient instructions for medications/treatments and a description of patient education materials (e.g., the name/title of the education material), mechanism of delivery (e.g., verbal discussion, brochures, films, etc.) and to whom given.
- Documentation should include the instructions given regarding follow up care and/or treatment.
- The patient's and patient's family's understanding of the follow up instructions received, and their ability to restate these instructions (e.g., repeat back).
- A letter sent to a patient and/or other caregivers.
- Complete all areas of any checklist. Do not leave empty spaces on any form. Place a line in the space, a "Ø", or "N/A" in the space if the item is not applicable.

Do not chart:

- Avoid subjective documentation and personal observations about the patient unless they are part of the medical history/examination. Any comments made should be regarded as accessible by the patient or patient's attorney.
- Do not blame another physician, care team member or facility.
- Avoid reference to payment delinquency or other billing information.
- Avoid reference to any communication with a professional liability insurance company.
- Avoid reference to peer review, incident reports and risk management calls to MPIE.

What attorneys look for:

- Vague, ambiguous, or contradictory statements
- Incomplete or sparse records that do not demonstrate consistent care
- Failure to follow up on recommendations made by other clinicians
- Failure to address signs or symptoms
- References to variance reports, risk management activities, quality assurance meetings
- Alterations; inaccuracies
- Time delays and gaps
- Illegible entries and or signatures
- Sloppy or illegible handwriting
- Failure to date, time, and sign a medical entry
- Lack of documentation for omitted medications and/or treatments
- Incomplete or missing documentation
- Adding entries later on
- Documenting subjective data
- Not questioning incomprehensible orders
- Using the wrong abbreviations
- Entering information into the wrong chart

Do not alter existing documentation or withhold elements of a medical record once a malpractice claim emerges, since the plaintiff's attorney or other third party usually already has a copy of the records. Changes are immediately obvious and even minor record alterations can greatly harm the provider's credibility. Should an "adverse event" occur, only document the facts surrounding the actual event and the subsequent care rendered as a result of the event. Avoid oral or written criticisms of health care previously provided by other practitioners. Since all pertinent facts about prior care are rarely available, caution is advised in making judgments and comments until all complete information is considered. Should a provider disagree with a past or current caregiver, a factual summary of clinical events and honest answering of patient inquiries is advised. Derogatory remarks about patients do not belong in the record. Since patients have legal access to their records, such remarks will only increase anger and patient dissatisfaction. Arguments and conflicts with other providers should never be included in the record. Finger-pointing, especially after an adverse event, will only make the defense of a case more complicated.

S.O.A.P. Format

The SOAP format is a standardized approach to note documentation in patient records. Whether you work in a busy clinic or operate a solo practice, keeping appropriate patient records is critical. While patient records are commonly used for treatment and counseling, these documents also are important from a medical-legal

standpoint.

The Problem Oriented Record (POR) is designed to provide a structured health plan to facilitate cooperative care of the patient's identified problems. A commonly used method to record progress notes in the POR is the SOAP.

The SOAP format, detailed below, is best used for patient evaluation and diagnosis.

Subjective: Information obtained from the patient and family members.
Objective: Data obtained from observation, physical examination, or diagnostic test results.
Assessment: Analysis of the problem, possible interactions of problems, and changes in the status of problems.
Plan: The planned treatment.

Resource: Patient SOAP Note Charting Procedures

Transcription

Transcription accuracy should be monitored regularly to ensure quality documentation and to ensure that medical transcriptionist professionals receive timely and consistent feedback. Transcription should be ready for review in a 24-hour turnaround time and be on the chart and approved within 72 hours of the visit. Ensure that dictated notes are authenticated (i.e. reviewed and signed by the responsible provider).
Attention to quality should reflect an understanding that even minor errors in the record potentially can impact medical decision making causing patient harm and creates risk for the provider by diminishing their credibility and perceived competence.

Electronic Health Record (EHR) Documentation

The technology associated with EHRs can be a contributing factor to claims. Several EHR-associated documentation issues commonly arise in medical malpractice litigation, including:

- Copy/paste
- Failure to review available data (e.g., test results, care team member notes)
- Alert overrides (e.g., patient screening questions for MRI)

Copy/Paste

The copy/paste habit threatens the integrity of the medical record. It can pose serious problems, such as regulatory concerns associated with the accuracy of documentation associated with billed services and increased vulnerability to

allegations of fraudulent claims. It can also put patient safety at risk. The medical record is designed to 'tell the patient's story' and each care team members relies on accurate information to deliver their aspect of patient care. When the medical record reflects inaccurate information, care team members may provide incorrect treatment leading to preventable medical errors.

Failure to review available data
The medical record operates as a communication tool among care providers. However, it can be difficult or time-consuming to navigate the EHR to extract necessary data and information. Providers are responsible for reviewing available and pertinent medical data and should request assistance from the health information management team or other care team members to locate the information necessary to provide care and treatment.

Alert overrides
Take notice and do not ignore or override alerts that are embedded into the EHR. These alerts are associated with high-risk processes (e.g., medication dispensing, MRI orders) and are typically designed through the guidance of established standards and best practices.

Medical record audits by a trusted peer or risk manager can help identify problematic documentation, such as those listed above. The results of medical record audits should serve as a learning opportunity for all providers and clinical team members and should not be used as a punitive tool.

Audit trails
The increasing use of electronic health records (EHR) has resulted in an increased ability to electronically track activities that occur within a specific medical record. This is accomplished by review of the metadata, audit trails, or audit logs.

An audit trail generally shows the sequence of events related to the use of a patient's electronic medical records, i.e., who accessed the records, when and where the records were accessed, and changes made to the records. Plaintiff attorneys can easily review a medical record and determine whether the copy/paste function was used, or amendments were made in documentation.

Scribes

All documentation guidelines are applicable when using scribes in the office and hospital settings. A scribed encounter is completed in the presence and at the direction of the provider and requires authentication. The scope and duties of the scribe are guided by certain accreditation and regulatory standards, third-party payor requirements, and guidelines associated with professional organizations, such as the

American Healthcare Documentation Group (AHDG). The general role of the scribe includes:

- Assisting the provider to navigate the EHR
- Responding to various messages as directed by the provider
- Locating information in the EHR for the physician to review (e.g., test results)
- Entering information in the EHR at the direction of the provider

It is recommended that providers select a scribe who is certified by the American College of Clinical Information Managers (ACCIM).

If organizational policies do not apply, develop policies and procedures that are consistent with the applicable standards and guidelines and address, at least:

- AACIM certification required
- A description of the scribe's roles and responsibilities, and scope of practice
- Scribe documentation guidelines
- Verbal orders may never be given to nor by scribes
- Provider review of the scribe's documentation and entry authentication
- Address the presence of the scribe in the examination room (e.g., patient education regarding scribes, changes in workflow)
- Applicable accreditation and regulatory standards
- Documentation auditing protocols
- How the scribe program will be monitored for compliance and effectiveness

Educate all staff members on the policies, procedures, and guidelines associated with the entity's scribe program.

For additional information and sample tools, See the American Health Information Management Association (AHIMA): "Using Medical Scribes in a Physician Practice" Journal of AHIMA 83, no. 11 (November 2012): 64-69, http://library.ahima.org/doc?oid=106220#.XKT9xfZFyUk

Documenting Phone Calls in Patient Charts

All telephone calls from patients relaying clinically-relevant information must be documented in the medical record. Phone calls requesting prescription refills, questions about advice or instructions given, health-related concerns, care follow-up calls, cancellations/no-shows, and test results must all be documented. Clinically relevant after-hours calls must also be documented in the medical record. The office should have a policy on how after-hours calls are documented in the medical record.

The individual who is taking the call is limited to addressing questions that are within his/her training, licensure, and expertise. Calls that are outside of the

individual's scope shall be delegated to the appropriate clinical team member. For example, a non-clinical staff member shall not provide advice related to the patient's symptoms of heart burn, and the call should be delegated to the physician.

Develop guidelines for managing patient calls:

1. Establish the essential elements of documentation:
   a. Clear statement of problem
   b. Symptom analysis as related to current health problem
   c. Allergy status if medications are involved
   d. Pregnancy status
   e. Assessment
   f. Document to whom the message was delegated
   g. Plan of care
   h. Medications prescribed or recommended
   i. Advice/instructions for further access to health care
   j. Guidelines for follow-up calls for significant medical advice given over the phone, per the provider's recommendation or established policy.

DO NOT GIVE TREATMENT ADVICE UNLESS DIRECTED BY THE PHYSICIAN OR YOU ARE AUTHORIZED BY LICENSURE TO DO SO.

Template Patient Encounter Forms

Template patient encounter forms, via paper and electronic, may be useful to create standardization and efficiencies for care that is commonly provided. For example, template forms are commonly used for endoscopies, chronic conditions, and commonly performed in-office procedures. Template forms should be periodically reviewed for accuracy and to ensure that the form properly captures the patient care that is provided during the encounter.

Template patient encounter forms should be periodically audited for:

- Consistent with the current standards of care
- Ample space on the form or electronic text box for physician or other care team member free text
- Space for drawings or electronic images
- Whether the appropriate form was used for the encounter. For example, using a physical exam form would not be appropriate for a sick visit
- Whether care team members are forced to enter documentation in other areas of the medical record that could be documented on the form through a simple form revision.
- Too much blank space or boxes makes the forms look like information was omitted or the exam was incomplete. Regardless, all spaces on a patient

encounter form, whether electronic or paper, should be completed. Evaluate whether repeated blank spaces add value to documentation and consider eliminating text boxes that are no longer consistent with the current standard of care or offer no value to properly documenting the encounter.

Resource: Patient forms available in various languages link

Unanticipated Outcomes, Incidents and Errors

Document unanticipated outcomes, incidents, and medical errors in the patient's medical record. It is particularly important to document what happened, what medical assessment and treatment was provided to address it, and the patient's response to treatment. Document disclosure conversations, as applicable.

The following guidelines have been provided to help guide documentation when an unanticipated outcome, incident, or medical error occurs:

- The medical record should contain all information regarding care and treatment of the patient in the appropriate place in the record (e.g., what happened, patient assessment, treatment, patient's response to treatment)
- Make the narrative factual and do not speculate as to the cause(s)
- Avoid terms such as "error" or "inadvertent"
- Do not place blame on others
- Record, by name, who on the medical team was notified (e.g., Dr. Smith notified and not 'doctor' notified)
- Describe the patient's condition, what was done in response to the error, and what Record any involvement of supportive persons, such as the chaplain or social worker
- Document what was told to the patient/family, by whom, and when; including disclosure conversations
- The medical record should not contain any references to Incident Reports or Risk Management. All risk management-associated documentation should be completed through established processes, such as incident reporting software, to preserve the confidential nature of such documents.

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Ownership

The medical record is owned by the physician or corporation under whom that physician works for when the medical record was created. It is a frequent patient misunderstanding that the medical record is theirs, while it is about their health, it is not their property. Patients do, of course, have a right to obtain a full and complete copy of their medical record with the appropriate authorization for release.

The use of patient portals has resulted in an increase in patient inquiries related to the appropriateness of his/her care. If a patient inquires about his/her care or requests a copy of their record because they are confused about a diagnosis or treatment or has questions about their care, offer to meet with the patient to discuss the contents of the record. It is not unusual for a patient to misunderstand medical jargon in the record and it may be helpful to offer this meeting to avoid misunderstandings.

Quality

The quality of the medical record is a major factor in determining liability. The following methods can be employed to reduce the risk of a poorly documented medical record:

- An individual medical record should be maintained on each patient seen in the office. Do not keep family charts.
- Patient identification should be verified. Assign patient identification numbers to assure there is no confusion of patients with the same or similar names. It is not recommended to use social security numbers due to identity theft concerns.
- Dictation (rather than handwritten) office notes is recommended for paper charts. Dictation should be done immediately, if possible, or at the end of the day. Dictation should be reviewed, initialed and dated by the author.
- Each entry in the medical record must be dated and timed.
- Each entry should be made in chronological order. If something significant is omitted, the entry should be made on the date the fact is recalled and labeled “late entry” or “subsequent note” or “supplemental note”.
- Do not leave large spaces between entries as this may be perceived as missing information or alleged to allow for information to be added later in this space.
- Do not erase, obliterate, or whiteout notes. When it is necessary to change or

amend notes, place a single line through the incorrect entry with your initials and date.

- Under no circumstances should a record be altered in any way (added note or correction) after a claim has been filed or if it is suspected that a patient will file a claim without first contacting MPIE.
- Records involved in a claim should be kept in locked storage separate from general records.
- A signature follows each entry, including the first name initial, complete surname and professional designation.
- Medical record entries are made for each visit and telephone consultation. Failure by the patient to keep a scheduled appointment and any follow up phone calls, reminder cards or letters sent by the office staff to reschedule the appointment should be recorded.
- Correct grammar and spelling are essential. There are a number of drugs, diagnoses and treatments with almost identical spellings but with very different characteristics and applications.
- Abbreviations are not recommended. The Institute for Safe Medication Practices (ISMP) and the Federal Drug Administration (FDA) have issued "do not use" lists of error prone abbreviations. ISMP and FDA recommend that the ISMP List be referenced whenever and wherever medical information is being communicated. This includes internal communications, telephone/verbal prescriptions, computer-generated labels, labels for drug storage bins, medication administration records, and pharmacy and prescriber computer order entry screens, as well as, product labeling, industry promotional materials, and medical publications.

Resources:
A list of abbreviations, intended meaning and misinterpretation may be found via:
ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

Retention

Each state provides minimum requirements for medical record retention. However, from the medical malpractice/legal perspective, the following medical record retention guidelines have been offered:

- **Adult records-** retain records for 10 years from the last date of treatment/visit.
- **Pediatric records**- retain records until the minor reaches 25 years of age.
- **Deceased patient's records**- retain records for 10 years from the date of death.
- **Obstetric patients**- who encountered difficulties- keep records for 21 years

from the birth of the child (unless neurologically impaired-see below)

- **Neurologically impaired adult or infant**- retain indefinitely.

Resource: State-specific medical record retention laws may be found via: https://www.healthit.gov/sites/default/files/appa7-1.pdf and Michigan-specific laws may be found here: http://www.legislature.mi.gov/(S(olicspyual303wvsdjbk3ubp))/mileg.aspx?page=GetObject&objectname=mcl-333-16213

Ensure that the medical record retention policy meets least the minimum state-based requirements. However, we recommend strengthening the policy to include the retention guidelines according to the medical malpractice/legal guidelines set forth above to maintain records for the length of time for the applicable statute of limitations for a medical malpractice claim and beyond.

Generally, the statute of limitations is two years from the date of discovery. Exceptions vary by state and generally include certain events that involve minors, medical injury to reproductive organs that results in the inability to procreate, and injury that is discovered after the two-year statute of limitations. There have been several challenges and exceptions to the two-year limitation by patients who file malpractice claims several years after the treatment was rendered. Therefore, some records should be retained indefinitely. The above guidelines are the recommended minimum lengths of retention time if indefinite retention is not possible.

HIPAA regulations as of April 4, 2003, require that all documentation relative to a health care provider's compliance with the regulation requirements, including patient requests for medical records accounting, be maintained for at least six years.

Physicians who are closing their medical practices due to relocation, merger, or retirement should refer to Chapter 8 of this Manual for more detailed information.

Maintenance/Storage

All records and diagnostic data must be secured to assure confidentiality and safety from loss, theft, or damage.

Many options exist for paper record storage such as storage facilities, microfilm, and CD-ROM imaging. If using a storage facility, a legal contract (a business associate agreement under HIPAA) between the physician and the custodian of the records is required. The contract should outline the responsibilities of the custodian to preserve the confidentiality of the records, handle requests for information or copies, and properly maintain the original documents. Rapid changes in technology may also need to be addressed so that documents stored electronically can be successfully retrieved in future years. No matter what form of storage is chosen the contract for off-premises storage of old records should be maintained with the permanent practice documents.

EHRs are either cloud or server-based systems. The best mechanism to preserve EHRs depends on the type of EHR system. Cloud-based EHRs can be maintained indefinitely with no need to involve a third party for record retention. Server-based EHRs require daily back-up system via CDs, USB ports, and other mechanisms to maintain electronic information. According to the HIPAA rules, the server-based EHR data must be transported daily to another location.

Radiology and Diagnostic Tests: Any patient record, x-ray film, or similar document sent off-premises for any reason should have a document completed and retained in the office noting the date sent, the individual authorizing, and to whom it was sent. This documentation is critical in the event of a medical negligence claim involving the missing record or film, as it establishes the "chain of evidence" and who the last responsible party was for the record or film. Unless prohibitive, copies should be sent, rather than originals.

Destruction

Medical practices should develop policies that address medical record retention and destruction schedules for both paper and electronic records. Paper medical records can be scanned to CDs and other devices for storage purposes. The destruction of paper medical records may be done through a third-party that demonstrates compliance with applicable medical record security and destruction laws. A business associate agreement is required when third-party companies are used to destroy medical records. A practice may also do their own shredding by using a shredding machine at the practice and ensuring that records are destroyed by shredding under your own supervision. Ensure that in-office medical record destruction practices are consistent with applicable state and federal laws, including HIPAA rules that address the management of PHI, that outline record retention and proper means for medical record destruction. The same rules that pertain to paper medical records are applicable to electronically-stored protected health information (PHI). The U.S. Department of Health & Human Services offers guidelines for the disposal of PHI, related to both paper and electronically stored PHI, via https://www.hhs.gov/hipaa/for-professionals/faq/disposal-of-protected-health-information/index.html

Release

A request for copies of records from a covered entity that contains protected health information (PHI) must be authorized by the patient or personal representative.
A covered entity is permitted to use and disclose PHI without an individual's authorization for purposes under certain circumstances including, treatment, payment, health care operations, and sometimes limited data for the purposes of research, public health, or health care operations.
Requests made by patients or other entities that do not fall under an exception

requires a valid written authorization for the release of health information must be completed by the patient or personal representative. The information provided should be the 'minimum necessary' to meet the objective.

According to the U.S. Department of Health and Human Services, the "Authorization for Release of Health Information" must contain specific information including:

- A meaningful description of the information to be disclosed
- The name of the individual or the name of the person authorized to make the requested disclosure
- The name or other identification of the recipient of the information
- A description of each purpose of the disclosure
- An expiration date or an expiration event that relates to that individual
- A signature of the individual or their personal representative

The rules are more stringent regarding the release of information related to mental health conditions, HIV, AIDS, substance abuse, and other conditions. Ensure that records related to such conditions are not released without the specific authorization by the patient or personal representative.

If the health care provider determines that disclosure of medical information may have an adverse impact on the patient, access may be denied. The health care provider shall provide a clear statement supporting that determination.

Additional guidance may be found via the American Health Information Management Association (AHIMA) http://library.ahima.org/doc?oid=85544#.XLYDdvZFyUk and the U.S. Department of Health & Human Services https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html and https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/authorization/index.html and the Michigan Legislature http://www.legislature.mi.gov/(S(olicspyual303wvsdjbk3ubp))/mileg.aspx?page=getObject&objectName=mcl-333-26265

Resource: Sample Patient Authorization to Release Health Information Template

Deceased Patient Records

Under Michigan law, the authority to release a patient's records succeeds to one of two classes of persons upon the patient's death. The first is the legal representative of the patient's estate — generally designated as Executor, Guardian, Administrator, or Trustee. The second is a beneficiary (or heir) of the patient's estate. This second group includes next-of-kin and other persons designated as beneficiaries under a will/trust, made by the deceased patient. A surviving spouse normally would qualify as a beneficiary, as well as immediate family members. If there is doubt about who is requesting a copy of medical records, **ask for proof.** Generally, a photocopy of the

deceased patient's trust or will, and a copy of the requestor's photo I.D. will suffice.

Practically speaking, physicians will know of a patient's death and will know the surviving family member(s). However, if the physician has not heard before about the patient's death, or has never met the purported family member, then requesting proof of both appears to be reasonable and prudent. Under state law, physicians are obligated to take reasonable measures to safeguard the confidentiality of medical records and to disclose protected medical information only to authorized recipients. Generally, death certificates and copies of the deceased patient's trust or will are readily available. Asking the requesting party to provide them should not present any significant problems or cause undue delay.

An Authorization for Release of Medical Records should be signed by the legal representative or beneficiary on the patient's signature line. The signer should print both name and status (e.g., Executor of the Estate, Beneficiary) next to his or her signature.

Access: What the Law Requires

Michigan's Medical Records Access Act (MCLA 333.26261 et seq) requires a health care provider or health facility to produce a copy of the medical record of a patient on receipt of a written request (signed and dated not more than 60 days prior). A copy and retrieval fee may be charged. This fee changes each year with the Consumer Price Index and can be found on the Michigan Department of Community Health website. Additional information may be found via: http://www.legislature.mi.gov/(S(olicspyual303wvsdjbk3ubp))/mileg.aspx?page=getObject&objectName=mcl-Act-47-of-2004

TO WHOM? A patient or his authorized representative.
WHEN? Within 30 days (unless held offsite, then within 60).
WHAT? The "medical record" is defined by law as "information (oral or recorded) in any form or medium that pertains to a patient's health care, medical history, diagnosis, prognosis, or medical condition and that is maintained by a health care provider or health care facility in the process of caring for the patient's health." **This means any EMR and all pages in the chart that pertain to that patient which the provider maintains as his or her medical chart.** The definition does not create any exceptions and **includes records of previous treaters if you have them in your chart.**

Non-Paying Patients

The physician cannot hold the medical record hostage due to non-payment or an outstanding bill. To do so entitles the patient to file a complaint with the Office of Civil

Rights and the Michigan Department of Community Health Bureau of Health Professions Complaint and Allegation Division.

Resource: Michigan Medical Record Access Act, Medical Record Access Act Fees (updated annually – the 2020 fee schedule is located here: https://www.michigan.gov/documents/mdhhs/Medical_Records_Access_Fees_2020_683553_7.pdf

Minors Medical Records

Confidentiality of Minor's Medical Records

Except as otherwise provided by law or if the minor authorizes it in writing, physicians are prohibited from telling the minor's parents or legal guardian about medical care the minor was legally able to authorize.

When a minor seeks medical treatment for which the minor has the legal power to consent, for example, treatment for the prevention and care of pregnancy, and the minor's parents have no knowledge of the proposed care, the physician will generally discuss with the minor the advantages of disclosing the proposed treatment to the minor's parents or guardian before services are rendered. The physician and minor should reach an understanding concerning 1) the extent to which the parents or guardians will be informed, 2) who is responsible for paying the cost of the medical treatment, and 3) to whom the physician can disclose the medical information that is necessary to obtain payment for the treatment. Minors should understand that it may be impossible to keep the information from their parents if the minor expects the parents' health plan to pay for the services.

Release of a Minor's Record to a Non-custodial Parent

Both biological parents **have the right** to their child's medical record, regardless of custody, unless there is a court order barring the parent from obtaining a copy of the records. Request to **see the original court order**-retain a copy in the child's medical record. If there is suspicion that the child or custodial parent might be in danger as a result of the release, **withhold release until the safety of both is verified** or a court order preventing the release is provided to the office. Neither parent has the right without the minor's consent to information **protected by state statutes** such as care and treatment related to **pregnancy, HIV, STD, substance abuse and mental health**–exceptions may apply–please see state statues for specifics on age requirements and release specifications or consult a risk management or legal advisor.

Step-parents **have no right to consent** to treatment or to the release of information on their step-children, **unless it is an emergency**, in which case treatment is warranted. Only a biological parent, adoptive parent or a guardian appointed by the court can consent. A step-parent may apply to obtain adoptive or guardian

status. In the absence of this, the office may request that the biological parent(s) accompany the minor for the initial visit at which the **biological parent may provide in writing their consent for their spouse/step-parent to consent** to treatment and information release. It is recommended that the **signature of the other biological parent** also be obtained to avoid any allegations that the child was treated without that biological parent's consent. **Verification** of signatures and identification may be obtained by visualizing the driver's licenses and obtaining a **photocopy** for the child's record.

Resource: Michigan Minor Consent Laws for Sexual Health

Providing Records to Subsequent Treating/Referral Physician

It is a myth that a physician's office must have an authorization from their patient to release records to a subsequent treating physician–especially one your office has referred that patient to see. By not providing the necessary medical information to a subsequent treating physician there is potential for a misdiagnosis or delay in diagnosis to occur due to the missing information, which may open the referring practice up to potential litigation surrounding the failure to supply necessary information to the subsequent treating physician. Provide all **appropriate** medical records to subsequent and referral physicians. Patient authorization is not necessary as the continuity of care would be implied by the patient's consent to treatment by the subsequent treating physician.

Providing Records to Attorneys

A copy of the patient's office record should be released to an attorney after the following conditions have been satisfied:

- The involved physician reviews the attorney's request and the record.
- The request includes an authorization dated and signed by the patient or includes a court order or other legally enforceable court mandate.
- Michigan Professional Insurance Exchange is consulted when there is indication that the request is being made for the purpose of evaluating a potential legal action against the physician.
- Document what information was sent.

Do They Really Mean "Any and All?"
YES THEY DO. Requests for production of medical records **from attorneys** (regardless of whether from an attorney that sues or defends health care providers) should be taken literally. **If all of a chart is requested, every piece should be copied and produced – including the back of a two-sided record, the phone slips and records from other providers.** Remember that the copying charges are set by law (MCLA 333.26269) and adjust annually.

Protect Yourself and Your Office
Numbering or bates stamping your medical record before it is copied is not required but ensures that everyone gets the same number of pages as the original. For example, if the original is numbered pages 1-48 and both plaintiff and defense attorneys have those exact pages, you have protected yourself against charges that one side didn't receive the entire chart.

As a general rule, when in doubt about the breadth of a request, simply call the requesting person to see what they really want or need. Doing so can save time, expense and trees, not to mention the credibility of your office, your facility, and your attorney.

Faxing Patient Information

It is the responsibility of the physician's office to safeguard the records of a patient; therefore, great care should be taken with facsimile transmission of medical information. Extremely sensitive information such as substance abuse, mental health, HIV and AIDS, and sexually transmitted diseases should not be faxed. Only in the event of a medical emergency (life or death) should this information be faxed directly to an Emergency Medicine physician per their request.

A good general rule regarding facsimile transmission of medical record information is to limit it to use by health care providers for **urgent or emergency patient care purposes.** Facsimile transmission of diagnostic test results shall be limited to the attending physician unless accompanied by a patient authorization. Facsimile cover sheets should always be used with any facsimile transmission and only the minimum amount of information necessary should be sent.

Extra caution is advised for users of EMRs with built in fax software. It is strongly recommended that any "fax to all" pre-programming functions be immediately disabled to prevent the inadvertent breach of PHI to non-intended recipients.

Electronic Health Records (EHR)

EMRs are helpful to the healthcare industry and can dramatically reduce the risk of malpractice. **True or False?**

Both true and false. There are many positives of EMR use, which will not be the focus of this section, this section will outline the areas of potential and foreseeable risk related to EMR use so that you may put practices in place to avoid these risks. The NEJM article "Medical Malpractice Liability in the Age of Electronic Health Records" outlines the area of increased risk.

- **Templates** - Documentation of clinical findings with EMR can easily be

paragraphs at the click of one box. All the boilerplate documentation creates a hazard in that findings that are truly important become difficult to find and may be missed – a significant cause of malpractice.

Solution: positive findings must be documented in a way that enables the reader to find them quickly – either by highlighting them or placing them in a separate section of the record.

- Using the **wrong template** can also cause defense problems – such as using a template that has information on it that would be impossible to obtain. For example incorrectly using an adult template on a child i.e., a neurological exam on a 1 yr old that included oriented to time, place, person.
- Recording of test and imaging results-ensuring that results are seen and acted on can become more of a challenge when they now sit in inboxes waiting for review. Especially challenging for the provider is the preliminary results vs. final results.

  Solution: only final results should be sent to physicians for review. Physicians must review the results in a timely fashion and not let their in box for results remain unchecked for more than one day. This job may be best delegated to a mid-level or RN as is frequently done with the paper record process.
- **Clinical decision support** systems record every pop up warning or drug interaction. If the physician fails to document reasoning for dismissing the warning and the patient has a reaction or adverse event the plaintiff will now have a record that the physician failed to heed the warning and without documentation why – the physician is left to explain his/her action on the stand to a jury.
- **EHRs that integrate email service** may leave physician open to wide spread breaches of PHI or open for the potential adverse events related to human error.

  Interface between EMR and paper records can create problems specifically in prescribed medications being canceled or defaulting to potentially dangerous dosages.
- **Copy and Paste functions** perpetuates errors made earlier. DO NOT ALLOW COPY AND PASTE FUNCTIONS IN THE HARD PROGRAMMING OF THE EMR.
- **Catch 22** – It will be asserted as the standard of care for a physician to use EMRs. Plaintiff lawyers will assert that the physician was obligated to use the newest technology available- especially if the claim is related to a medication error or adverse drug interaction that the EMR would have caught. Further because EMRs make it easier to track test results and patient follow up and it is much easier to access and review medical history the plaintiff attorney

will assert that the physician's failure to use EMR to avoid medical errors constitutes malpractice.

Resource:
Paterick, Zachary R et al. "Medical liability in the electronic medical records era." Proceedings (Baylor University. Medical Center) vol. 31,4 558-561. 11 Sep. 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6413973/

Electronic Health Record (EHR) Legal and Insurance Considerations

Top issues in medical malpractice litigation

- Copy/paste
- Failure to review available data (e.g., test results, care team member notes)
- HIPAA violations
- System interface failure
- Subjective remarks (e.g., defensive documentation, blaming others)
- Unexplained additions
- Alert overrides (e.g., patient screening questions for MRI)

Overcome these issues with policies, procedures and practices that address the scope of the legal medical record and outline the applicable standards for EHR management. Generally, the standards encompass proper documentation (addressed in the Documentation section), maintaining the EHR, patient portals, release of information, and HIPAA/HITECH and Meaningful Use.

Maintaining EHR

Patient portals. P&P addresses the operational aspects, such as portal use, physician-patient relationship, proper use of the portal from the provider and patient perspective, termination of use, password requirements, timeframe for response to messages sent through the portal, how those messages are integrated into the EHR, security/audits, type of information available on the portal. Issues include urgent messages by the patient sent through the portal, posting critical/abnormal test results before the office has communicated the results to the patient, security breaches.

HIPAA

Release of information. Printed copies of EHRs. Printed Ensure the printed copies reflect the care that has been provided.

Data breach. Cyber risk and safeguards to protect against.

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Medication Errors

Risk assessment: Medication error risk points can be identified through a five-pronged analysis of errors. The first two prongs are reactive in nature and include:

- Investigation and analysis of practice site-specific errors that have caused some degree of patient harm and
- Analysis of aggregate medication error data (e.g., trends by particular drugs or storage location of medications involved in errors) whether or not harm has occurred.
- Equally important are the other three prongs. Proactive in nature, these include:
  - The investigation and analysis of "near misses" (errors that have the potential to reach the patient or cause patient harm),
  - Review of "external" errors, those that have occurred in other organizations (using the ISMP Medication Safety Alert!®, the Action Agendas, TJC's Sentinel Event Advisories, or news stories), and
  - Identification of potential risk points using proactive risk assessment tools (such as the ISMP Self-Assessment, FMEA, or staff surveys).

Each prong contains valuable information about weaknesses in the system which, collectively, can lead to the identification of effective error-reduction strategies.

Prevention of medication errors: Medication errors are not the fault of any one person but are the result of breakdowns in the complex health care delivery system. The question of who was involved is of less importance than what went wrong, how, and why.

Quick Tips for Medication Error Prevention

To prevent medication errors, written medication orders should:
• Be legible • Include complete information • Consider patient-specific information • Avoid abbreviations • Express weights, volumes, and units using the metric system • Avoid decimals • Deal cautiously with drug names • Include the medication's purpose

Complete information means:
• Patient Name • Patient-specific data • Generic and brand name • Drug strength • Dosage form • Amount • Explicit directions for use (NOT “use as directed”) • Purpose • Refills
Always obtain and consider the following patient-specific information when prescribing medications:
• Age • Weight • Renal and hepatic function • Concurrent disease states • Laboratory test results • Concurrent medications • Allergies • Medical/surgical/family history • Pregnancy/lactation status
Do NOT use abbreviations:
• Spell out Drug names • Daily, NOT QD or OD • Unit, NOT U • Every other day, NOT QOD • Subcutaneous, NOT sc or sq • And, NOT a/ or & • Cubic centimeter, NOT cc
Use caution with look-alike and sound-alike names. For example:
• Accupril® Accutane® • Alprazolam® Lorazepam® • Cardene® Cardura® • Flomax® Fosamax® • Lamisil® Lomotil® • Nizoral® Neoral® • Plendil® Prilosec® • Zantac® Zyrtec®

Weights, measures, and volumes:
• Use the metric system • Avoid the apothecary system
Decimals:
• Avoid decimals when possible • 500 mg, NOT .5 g • 125 mcg, NOT .125 mg • Never leave a decimal point “naked” • Haldol 0.5 mg, NOT .5 mg • Never use a terminal zero behind the decimal • Colchicine 1 mg, NOT 1.0 mg • Separate name and dose by a sufficient space: Inderal 40 mcg, NOT Inderal40mcg
Patient Education:
• Educate patients about their medications • Name of medication • Purpose • Dose and dose frequency • Side effects and adverse reactions • Restrictions on OTC drugs, herbal remedies, and natural medication supplements • Provide patients with understandable, written instructions • Involve patients in check systems by having them communicate with the pharmacist • Inform patients about the potential for error with drugs known to be problematic (look- and sound-alikes) • Educate patients about the use of medication administration devices • Dropper • Oral syringe • Measuring teaspoon, not tableware teaspoon

Used with permission of Vincenza Snow, MD, FACP; ACP Director, Clinical Programs and Quality of Care.

Investigation of Medication Errors

Conducting Root Cause Analysis, using ISMP’s ten key system elements as a framework, can shed light on the underlying causes of the error, and on improvements that could be made to mitigate chances of recurrence.

Medication use is a complex process that comprises the sub-processes of medication prescribing, order processing, dispensing, administration, and effects monitoring. The key elements that affect the medication-use process are listed below. The interrelationships among these essential elements form the structure within which medications are used.

Patient information: Obtaining the patient's pertinent demographic (age, weight) and clinical (allergies, lab results) information that will assist practitioners in selecting the appropriate medications, doses, and routes of administration. Having essential patient information at the time of medication prescribing, dispensing, and administration will result in a significant decrease in preventable adverse drug events (ADEs).

Drug information: Providing accurate and usable drug information to all healthcare practitioners involved in the medication-use process reduces the amount of preventable ADEs. Not only should drug information be readily accessible to the staff through a multitude of sources (e.g., drug references, formulary, protocols, dosing scales), it is imperative that the drug information is up to date as well as accurate.

Communication of drug information: Miscommunication between physicians, pharmacists, and nurses is a common cause of medication errors. To minimize the number of medication errors caused by miscommunication, it is always important to verify drug information and eliminate communication barriers.

Drug labeling, packaging, and nomenclature: Drug names that look-alike or sound-alike, as well as products that have confusing drug labeling and non-distinct drug packaging significantly contribute to medication errors. The incidence of medication errors is reduced with the use of proper labeling and the use of unit dose systems.

Drug storage, stock, standardization, and distribution: Standardizing drug administration times, drug concentrations, and limiting the dose concentration of drugs available in-patient care areas will reduce the risk of medication errors or minimize their consequences should an error occur.

Drug-device acquisition, use, and monitoring: Appropriate safety assessment of drug delivery devices should be made both before their purchase and during their use. Also, a system of independent double-checks should be used within the institution to prevent device-related errors such as selecting the wrong drug or drug concentration, setting the rate improperly, or mixing the infusion line up with another.

Environmental factors: Having a well-designed system offers the best chance of preventing errors; however, sometimes, the environment in which we work contributes to medication errors. Environmental factors that often contribute to medication errors include poor lighting, noise, interruptions, and a significant workload.

Staff competency and education: Staff education should focus on priority topics, such as new medications being used, high- alert medications, medication errors that have occurred both internally and externally, protocols, policies, and procedures related to medication use. Staff education can be an essential error prevention strategy when combined with the other key elements for medication safety.

Patient education: Patients must receive ongoing education from physicians, pharmacists and the nursing staff about the brand and generic names of medications they are receiving, their indications, usual and actual doses, expected and possible adverse effects, drug or food interactions, and how to protect themselves from errors. Patients can play a vital role in preventing medication errors when they have been encouraged to ask questions and seek answers about their medications before drugs are dispensed at a pharmacy or administered in a hospital.

Quality processes and risk management: The way to prevent errors is to redesign the systems and processes that lead to errors rather than focus on correcting the individuals who make errors. Practical strategies for reducing errors include making it difficult for staff to make an error and promoting the detection and correction of errors before they reach a patient and cause harm.

Resources: Institute for Safe Medication Practices

Special Issues:

Allergies

Each new patient should be questioned regarding allergies they may have. This can be accomplished using a three-step approach:

1. Utilize a new patient questionnaire that asks patients if they have any allergies to medications.
2. The office nurse, in reviewing and clarifying the answers to the questionnaire, clearly questions the patient regarding any history of drug allergy.
3. The physician obtains and appropriately documents a thorough patient history to avoid the prescription of contraindicated drugs. Before prescribing medications, the physician again asks about allergies to drugs.

For established patients, update allergies at each new visit and when receiving a new prescription by telephone. Allergies to over the counter (OTC) or herbal medications are also included.

The five traditional rights of medication administration are followed when drugs are administered in the office.

- Right patient
- Right drug

- Right route
- Right time
- Right dose

A red sticker or other prominent identifier placed on the medical record jacket will alert the physician and staff that the patient has an allergy. All medical records should have a sticker. Do not leave this sticker blank. If the patient has no known drug allergies, indicate with "NKDA." Every entry should be dated and initialed. Allergies should be documented on the problem list or other standardized chart forms that are easily accessible in the chart.

Reactions to Medications

Office protocol should outline emergency steps to be taken in the event of a severe reaction to a medication. The policy should also identify medications that can be given only when the physician is in the office.

Drug Interactions

Ask all new patients and periodically ask regular patients what medications they are taking and whether they are seeing other physicians who prescribe for them. Many patients do not think it is crucial for a doctor to know about drugs they are receiving from other physicians.

Guard against possible interactions with over-the-counter (OTC) drugs and supplements. Please do not presume that patients have read and understood the warning label for the products they are taking. In many cases, patients will not voluntarily inform their physician that they are taking such products.

Telephone Prescriptions

Before renewing a medication via the telephone, the physician should review the medical record. Before ordering a new prescription, the physician should inquire about allergies and all medications currently being taken. Following the call, the conversation and any action taken shall be documented.

After-hours telephone calls that include the prescription of medications should be documented at the time of the call and then placed in the medical record the next business day. Also, the patient's primary care physician must be informed. A message pad or Dictaphone carried by the doctor are excellent aids for accomplishing this task.

Prescription Pads

Prescription pads must not be left in examination rooms and should not be pre-signed or post-dated. Physicians can carry a pad with them while in the office. At the

end of office hours, pads should be stored in one location and locked. Any electronic prescription devices should be secured with a password so that they cannot be used by anyone other than the intended user.

Medication Record Log

A medication list that documents drug allergies, adverse reactions, and all medications prescribed, including renewals, can be found in the medical record. All pertinent data is in one place, which facilitates the on-going evaluation of the patient's drug therapy. In some legal cases, information that would have alerted the physician to a potential problem was scattered throughout the record and was missed by the physician.

Controlled Substances

The systems for ordering, storage, and dispensing of controlled substances in the office should be organized and periodically evaluated as to the security of such drugs and the safety of personnel.

Policies and procedures should be developed for the following:

- Prescribing and dispensing medications.
- Use of product samples and sample logs.
- Drug ID control numbers.
- Control of supplies and drugs (e.g., needles, syringes, drugs).
- Mandatory recording of vaccinations.
- Reporting of adverse drug events.

Prescription Fraud

The Drug Enforcement Administration, the agency in charge of the enforcement of the Controlled Substances Act and regulations, published a "Pharmacist's Guide to Prescription Fraud" in 2000, to guide pharmacists who encountered fraudulent prescriptions. The guidance provided that when dealing with controlled substances, and there is a question concerning any aspect of the prescription order, the first step is to call the prescriber for verification or clarification. Other measures to take if there is a discrepancy are to have the patient provide a plausible reason before the prescription medication is dispensed or to request identification.

If, however, a pharmacist believes that he or she has a forged, altered, or counterfeited prescription, the DEA is clear in its guidance: don't dispense it; call the local police. Michigan law implicitly expects the same conduct as it requires that pharmacists use "good faith" in prescribing controlled substances and advises that pharmacists follow "nationally accepted professional standards," like this DEA guidance, in dispensing controlled substances. MCL 333.7333

Further, the DEA advises that if a pharmacist believes that there exists a pattern of prescription abuses, he or she should contact the Michigan Board of Pharmacy or the local DEA office.

This guidance was written specifically for pharmacists. If a pharmacist does not perform their proper duty of contacting the local police in the event of a forged, altered, or counterfeited prescription, and instead calls the physician practice from which the alleged fraudulent order came, the practice should take the recommended step and contact the local police or at least encourage or insist the pharmacist do so.

The DEA, in its Guide, encouraged local pharmacists and physicians to develop a network, or at least a working relationship, which promotes teamwork and camaraderie. Establishing a simple, consistent process for reporting prescription fraud would be an ideal form of communication between pharmacists and physicians to protect the DEA number of prescribing physicians and ensure that proper reports are filed.

Contributed by Megan M. Hard, Attorney, Smith, Haughey, Rice, and Roggee

Sample Medications

Physician offices frequently dispense sample medications. Complimentary starter doses have proven to be of benefit for patients, particularly those without adequate financial resources. However, sample medications are not free because when properly monitored, they cost the practice in both physician and staff time. Physician office policies and procedures should address the following issues:

- Accept only medication samples approved by physicians, i.e., office formulary.
- Medication samples are locked.
- Medication samples are logged in by staff or pharmaceutical representatives.
- Pharmaceutical representatives should only be allowed in designated areas.
- Samples need to be labeled with patient instructions.
- Medication samples are logged out by physicians on a form that includes the lot number.
- Patient education sheets should be available for all medications utilized.
- Documentation in medical records that sample medication was given.
- Samples are checked monthly for expired dates.

Medication Storage and Access

All medications are to be stored in strict compliance with the manufacturer's directions for storage or USP standards for storage before use.

Medications requiring refrigeration are to be stored in the medication refrigerators located in the medication rooms. No food is to be stored in the medication

refrigerators. Each refrigerator is to be equipped with a thermometer which should be periodically checked for appropriate temperature.

Drug Storage requirements are as follows: Refrigeration: 36-46F, Freezer: 4-14F, Cool Place: 46-59F, Room Temperature: 59-86F.

Medication room doors must be closed and locked at all times. Carts, cabinets, and other areas containing medications must be locked at all times when not in use.

Access to medications is by licensed/registered practitioners only, with non-licensed staff requiring observation, with the following exceptions: Materials Management staff, and Anesthesia technicians in the scope of their duties. Included in the list of personnel that must be supervised are housekeeping personnel.

A qualified designee (practice manager, clinical staff member) conducts at least monthly inspections of all medications being stored and appropriately destroys expired medications.

A record of monthly inspections is to be maintained for one year to verify that the requirements of medication storage are being met.

Special Article: Medication Safety Issues in the Office Setting

By Karin M. Proos, PharmD, Pharmacy Director, Spectrum Health Medical Group

Let's begin with an example of a mediation error. A physician prescribes a new inhaled mediation for a patient. The physician sends the prescription to the retail pharmacy and assumes the pharmacy will educate the patient on inhaler use. The pharmacist fills the prescription with the new inhaler and assumes the physician's office educated the patient. The patient picks up the prescription from the pharmacy and doesn't know how to use the inhaler at home. No one educated the patient and both the physician and the pharmacist are at fault. This is one type of medication error that will be discussed in more detail later in the chapter.

Medication safety issues are a growing concern. While a lot has been done in hospitals to improve medication errors and adverse drug events, the majority of health care is delivered in physician offices and clinics. In fact, 75% of all physician visits end in the prescription of a drug.[1] This translates into over 3 billion prescriptions filled outside the hospital each year in the US.[2] Yet, for every 1000 prescriptions written, there are 40 that involve a medical error.[2] And for every dollar spent obtaining a medication, $1.33 is spent to treat a resulting adverse drug event.[3] Although it is difficult to estimate the rate of adverse drug events in ambulatory care, it may be as high as 27%.[4] Both adverse drug events and medication errors are important medication safety concerns in the medical office setting.

Some of the most commonly prescribed medications are associated with medication errors.[5] As with most things that become "common practice", there is less awareness in performing safe practices when certain medications are used over and over again. For example, you may be less cautious with a medication you prescribe or refill multiple times a day, every day. Whereas, you will be more careful with a prescription when it is only ordered once a year. According to a statistic from the early 1990s, 1 out of every 131 outpatient deaths is the result of a medication error.[6] It is unlikely this statistic has improved with time.

Table 1: Greater task complexity leads to a higher error rate	
Steps in a process	Chance of an error
1 step	5%
5 steps	33%
25 steps	72%
50 steps	92%

Not only do errors occur with frequent medication use but also with multiple steps in a process. If prescribing a medication only took one step, the likelihood of an error would be 5%.[7] But if it takes five steps, the chance of an error increases to 33%.[7] Increase the number of steps in a process to twenty-five or fifty and the likelihood of an error rises to 72% and 92%, respectively.[7] It probably takes about ten steps to process a prescription so your risk of error is somewhere between 33% and 72%. As you can see, the more complex a process is, the higher the risk of an error.

The American College of Physicians published, Take Home Points for Patient Safety which states a clinician's risk of making a medical error is 17 times higher if (s)he is unfamiliar with the task.[7] For example, if a staff person is asked to perform a point of care test on a patient but (s)he was never trained how to use the point of care meter, there is a 17 times higher risk of error than if (s)he was familiar with the meter. Another risk factor for medical errors is trying to see two patients in a fifteen-minute time slot. In this example of time shortage, the risk of an error is 11 times higher than if you had enough time to see each patient for fifteen minutes. Information overload is another risk factor resulting in a 6 times higher rate of error. This error will be discussed in more detail later in the chapter.[7] There are a lot of variables that cause medical errors. Most errors are a result of one or more breakdowns in a process, not a person.

Table 2: System factors that impact patient safety	
Risk factors	Higher rate of error
Unfamiliarity with task	17 times

Time shortage	11 times
Information overload	6 times
Misconception of risk	4 times
Inadequate checking	3 times

One group of family physicians and their office staff evaluated all of their medication errors in an attempt to fix faulty processes.[8] They found that their errors could be grouped into five categories:

- *prescribing errors (70%),*
- *medication administration errors (10%),*
- *documentation errors (10%),*
- *dispensing errors (7%), and*
- *monitoring errors (3%).*

This chapter will follow the same classification system. Since the survey found that the most common errors were prescribing errors, we will start there.

Prescribing

Prescribing errors with handwritten prescriptions are well documented and are at the forefront of many discussions as we move toward electronic prescribing (e-prescribing). Some of the biggest concerns with handwritten prescriptions are:

- illegibility,
- missing dose or directions,
- lack of real-time decision support tools, and
- theft of prescription pads.

It is projected that advanced e-prescribing will prevent 76% of these avoidable errors each year.[5] However, e-prescribing is not fail-proof and there are a variety of prescribing errors that can occur such as; overwhelming product selection, look-alike name confusion, and overriding safety alerts.

E-prescribing error #1 – Overwhelming product selection

Electronic systems can, and do, provide the clinician with every prescription, over-the-counter (OTC), vitamin and herbal product available on the market. Currently, there are over 10,000 prescription drugs and more than 300,000 OTC medications.[2] If you type “acetaminophen”, into an electronic system you will get over 170 products. To reach the first prescription product, acetaminophen with codeine, you need to scroll through at least 50 varieties and doses of OTC acetaminophen. With so many varieties of the same product to choose from, you can easily pick the wrong one.

Diagram 1: Medication order for acetaminophen

ACETAMINOPHEN | Search | Preference List (F5) | Database Lookup (F7)

Code	Name	Copay	Coverage	Formulary	Type
18433	ACETAMINOPHEN 100 MG/ML PO SOLN			Unknown	Generic OTC
103	ACETAMINOPHEN 120 MG RE SUPP			Unknown	Generic OTC
8941	ACETAMINOPHEN 160 MG PO CHEW			Unknown	Generic OTC
27867	ACETAMINOPHEN 160 MG PO CPSP			Unknown	Generic OTC
8945	ACETAMINOPHEN 160 MG PO TABS			Unknown	Generic OTC
39713	ACETAMINOPHEN 160 MG PO TBDP			Unknown	Generic OTC
16962	ACETAMINOPHEN 160 MG/5ML PO ELIX			Unknown	Generic OTC
36769	ACETAMINOPHEN 160 MG/5ML PO GEL			Unknown	Generic OTC
26969	ACETAMINOPHEN 160 MG/5ML PO LIQD			Unknown	Generic OTC
100	ACETAMINOPHEN 160 MG/5ML PO SOLN			Unknown	Generic OTC
8943	ACETAMINOPHEN 160 MG/5ML PO SUSP			Unknown	Generic OTC
24421	ACETAMINOPHEN 167 MG/5ML PO LIQD			Unknown	Generic OTC
101	ACETAMINOPHEN 325 MG PO TABS			Unknown	Generic OTC
40525	ACETAMINOPHEN 325 MG PO TBDP			Unknown	Generic OTC
104	ACETAMINOPHEN 325 MG RE SUPP			Unknown	Generic OTC
83568	ACETAMINOPHEN 325 MG/10.15ML PO SUSP			Unknown	Generic OTC
13794	ACETAMINOPHEN 325 MG/5ML PO SOLN			Unknown	Generic OTC
98	ACETAMINOPHEN 500 MG PO CAPS			Unknown	Generic OTC
77730	ACETAMINOPHEN 500 MG PO CHEW			Unknown	Generic OTC
102	ACETAMINOPHEN 500 MG PO TABS			Unknown	Generic OTC
40526	ACETAMINOPHEN 500 MG PO TBDP			Unknown	Generic OTC
14201	ACETAMINOPHEN 500 MG/5ML PO LIQD			Unknown	Generic OTC
13410	ACETAMINOPHEN 650 MG PO TBCR			Unknown	Generic OTC
105	ACETAMINOPHEN 650 MG RE SUPP			Unknown	Generic OTC
83569	ACETAMINOPHEN 650 MG/20.3ML PO SUSP			Unknown	Generic OTC
99	ACETAMINOPHEN 80 MG PO CHEW			Unknown	Generic OTC
27866	ACETAMINOPHEN 80 MG PO CPSP			Unknown	Generic OTC
27883	ACETAMINOPHEN 80 MG PO TBDP			Unknown	Generic OTC

Split View | Medications | Procedures | Order Panels | Accept Selection | Cancel

E-prescribing prevention strategy #1 – Preference lists

For this reason, most electronic systems allow you to create a personalized list of medications you commonly prescribe. If you are an internist and most of your patients take acetaminophen 500 mg tablets, you can put this product on your preference list. The next time you type “acetaminophen”, your preferred product will appear first.

Diagram 2: Develop a preference list

ACETAMINOPHEN | Search | Preference List (F5) | Database Lookup (F7)

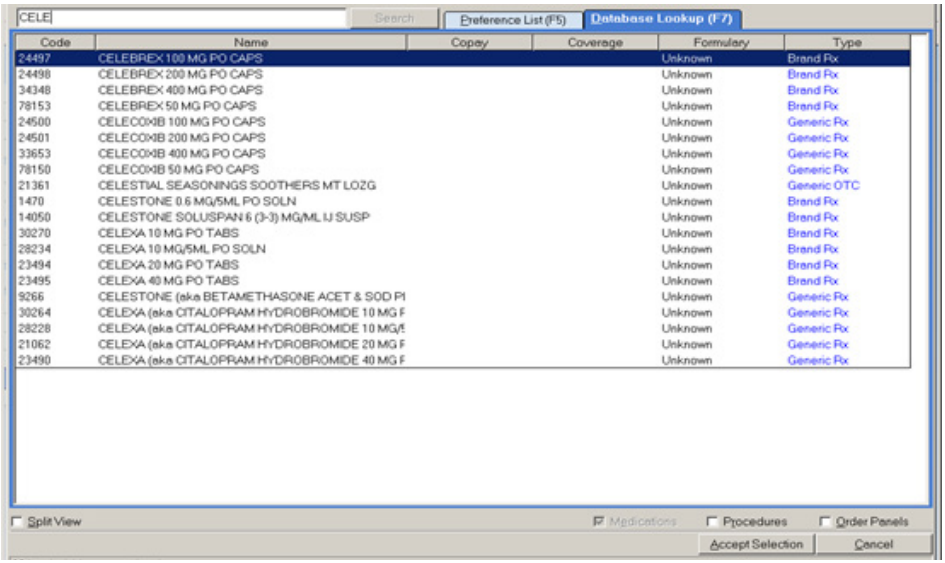
Code	Name	Type	Dose	Route	requenc	Pref List	Copay	Coverage	Formulary	Type
102	ACETAMINOPHEN 500 MG PO TA	Medicatic	500 mg	Oral	EVERY	CLINICIAN, K			Unknown	Generic OTC

Split View | Medications | Procedures | Order Panels | Accept Selection | Cancel

E-prescribing error #2 – Look-alike name confusion

There are a lot of medication names that look-alike with similar beginnings or endings. For example, if you type in part of a word like, “cele” or use the short codes offered by the electronic systems such as, “cel20”, you will get both Celebrex® and Celexa® in your list of options. If you select the first product without looking at the entire name, you can send the wrong prescription to the pharmacy. If the medication is new to the patient, the pharmacist may not know that it is the wrong prescription to fill.

Diagram 3: Medication order for ‘cele’



E-prescribing prevention strategy #2 – Tall MAN lettering

The Institute of Safe Medication Practices (ISMP) recommends the use of “Tall MAN” lettering.[9] This is the use of capital letters within a medication name to highlight different parts of the name. In the example of Celebrex® and Celexa®, the different endings of the medication names are highlighted using Tall MAN letters; CeleBREX and CeleXA. Many retail and hospital pharmacy computer systems already use this nomenclature. Once there is standardization, it is expected to spread to all electronic systems in the future. Using this lettering system can even help clarify handwritten prescriptions. A list of drugs with Tall MAN lettering can be found at www.ismp.org.

Table 3: Examples of some drug names with Tall MAN letters	
hydrALAZINE – hydrOXYzine	ALPRAZolam – LORazepam
buPROPion – busPIRone	ceFAZolin – cefTRIAXone
glipiZIDE – glyBURIDE	CeleBREX – CeleXA
predniSONE – prednisoLONE	clonazePAM – cloNIDine
NovoLOG – NovoLIN	HumaLOG – HumuLIN
metroNIDAZOLE – metFORMIN	LaMICtal – LamISIL
oxyCODONE – OxyCONTIN	PriLOSEC – PROzac
traZODone – traMADol	ZyPREXA - ZyrTEC

E-prescribing error #3 – Overriding safety alerts

Approximately 6.6 to 10% of all electronic prescriptions trigger a concurrent safety alert.[5,10] With over 3 billion prescriptions filled annually in the US that means 198 to 300 million safety alerts are triggered each year.[2,10] To break it down even further, over 500 thousand medication safety alerts trigger every day in the US. With so many alerts and decision support tools "flagging" during medication prescribing, clinicians get fatigued and miss important information. This type of information overload increases the risk of errors by six times the normal rate. An analysis by Isaac and colleagues showed clinicians overrode 90.8% of all drug-drug interaction alerts.[10] A similar statistic of 88% was noted with pharmacists several years ago.[5]

E-prescribing prevention strategy #3 – Awareness

Although this safety issue is quickly recognized, its solution is not. One suggestion is to limit the drug-drug interaction alerts to only those listed as major or high-severity. In the same study by Isaac and colleagues, clinicians accepted the high-severity interaction alerts only slightly more often than the moderate- or low-severity alerts (10.4%, 7.3%, and 7.1%, respectively, $p<0.001$).[10] Another suggestion is to require clinicians to provide an override reason, such as "benefits outweigh risks" or "clinically insignificant". It forces clinicians to respond to the safety information reported. Periodically, these reasons can be evaluated and used to down-grade or remove some inappropriate alerts. However, it is one more step the clinician must complete during medication order entry. And the more steps in a process, the increased risk of error.

Medication Administration

As the name states, administration errors involve inappropriately giving medications in the office practice. Also included in this category is incorrectly ordering products from the manufacturer or wholesaler and improperly storing medications. Improper storage includes failure to maintain a locked cabinet for controlled substances. Another storage issue is keeping medications and samples with similar, look-alike names, or packaging next to each other. However, the administration error that most directly impacts the patient is failure to follow the five rights of medication use.

The five rights should be verified before giving any medication; missing any one of these rights can result in a medication error. The five rights of medication use include the

- right patient,
- right drug,
- right dose,
- right route, and
- right time.[11]

Medical offices need to establish systems or processes that ensure staff can verify the five rights every time a medication is given. Let's look at the following situation to discuss the five rights.

Dr. Smith leaves patient A's room and starts to enter patient B's room. Dr. Smith sees his medical assistant, Betty, coming down the hall. Dr. Smith points down the hall and says, "She needs a shot of Depo-Provera®". Betty says ok and continues with her current task. Bobby, another medical assistant sees Betty is busy and says, "Betty, I'll draw that up and leave it here on the counter". Once Betty completes her previous task, she sees an unlabeled syringe sitting on the counter. Betty assumes it is the Depo-Provera® injection and gives it to patient A.

Administration error #1 – Incomplete verbal orders

In this situation, the first safety concern is that the physician verbally orders a medication without complete instructions. Betty is missing the dose, route, and time of the medication. She also doesn't know the specific patient that needs the medication. Ultimately, she is missing four of the five patient rights. Since it is a "verbal" order, it is not recorded in the chart and staff cannot complete the task of administering the medication without getting additional information from the physician.

Administration prevention strategy #1 – Written documentation

To make this a safe practice, the physician should enter all orders in the patient's

chart. Having the order in the chart eliminates a lot of assumptions, especially for staff. A written order allows staff to check themselves against a written order for the right drug, dose, and route. In this case, Betty can also verify that she is giving it to the right patient at the right time. A written order also provides staff with a reason to document the delivery of a medication to a patient. If there is an error or adverse event and no written order, the staff person is held responsible for administering medication without a physician order.

Administration error #2 – Unconfirmed drug and dose

The second safety concern is that Betty and Bobby do not check each other's work. The physician never specified a dose in his verbal communication so Bobby draws up a common dose. Bobby doesn't leave the vial next to the syringe so Betty can't check what dose Bobby drew up nor can she verify that Bobby used the right drug to complete the order.

Administration prevention strategy #2 – Double check system

A safe office practice is to have staff members double-check each other; especially with vaccines, high-risk medications like insulin, and controlled substances like testosterone. A double-check consists of the first staff person showing the vial, syringe, and medication order to a second staff person.[12] The second staff person compares the vial and syringe against the written order and confirms it is the right drug, dose, and needle size for route. Setting up this safe office practice enables staff to follow the five rights of medication administration as part of their daily routine.

Administration error #3 – Lack of responsible person

In the above scenario, Bobby draws up the medication but does not administer it. He puts the vial away and leaves the syringe on the counter unlabeled. There is no way for Betty to confirm the drug or dose. Yet Betty administers the medication and documents it in the chart. If there is an error or adverse reaction, Betty's name is attached thus assumes all of the responsibility for the medication administration. She cannot say, "Bobby drew it up for me so I am not responsible".

Administration prevention strategy #3 – Single person administration

While teamwork is recommended, this is not an area where handoffs are appropriate unless safety steps are established. If one staff person draws up a drug but leaves it for a second person to administer, the first person must label the syringe so the second person administering the medication knows what drug and dose are in the syringe. The label must also state the patient's name and the date drawn up. Due to the complexity of this process, a safer office practice

is to have staff administer the products they prepare. The staff person that administers the medication, and that person alone, is responsible for the accuracy of the medication delivered. (S)he knows the vial selected, the dose drawn into the syringe, and the needle size attached to the syringe and has performed the above-mentioned double-check. When a staff person signs his/her name to the medication administration order, (s)he knows every step in the process was completed to ensure safe mediation administration.

Documentation

While documentation is very important in healthcare there are often multiple locations to enter the same information; whether it is several places within the patient's chart or on log sheets, forms, or databases outside of the chart. However, there is one item that, for the most part, only resides in a single location but is often incomplete. That item is the patient's medication list. Since there are so many components and it is a vital piece of the patient's chart, an incomplete medication list is the most common error in documentation.

Documentation error #1 – Incomplete medication list

In most patient charts, the prescription medication names are listed but the doses, routes, frequencies, and refill histories are often missing. As a result of this missing information, the physician's medication list is no longer considered the "source of truth". This is problematic as the physician's medication list is used to assess if diseases are under control. For example,

A patient with uncontrolled hypertension is taking lisinopril 20 mg twice a day. The medication list in his chart states lisinopril 20. The physician assumes that the patient is taking 20 mg once a day. The patient's blood pressure is still too high so she "increases the dose" and writes a new prescription for lisinopril 40 mg once a day. She thinks she is increasing the patient's dose of lisinopril but in reality, she is continuing the patient on the same dose – 20 mg twice a day is the same as 40 mg once a day.

Documentation prevention strategy #1 – Complete information

A complete list of prescription medications includes the name, dose, route, and frequency of each medication. The list also includes the last date of a refill, the number of refills given, and the names and phone numbers of the pharmacies used by the patient. Medication allergies and the resulting reactions are also important for a complete medication list. Knowing if the patient simply had a side effect such as stomach upset or a serious adverse reaction such as hives helps the physician know which medications to prescribe with minimal consequences. The

more accurate the medication information, the less likely an error will occur.

Documentation error #2 – Missing non-prescription products

Medication lists often lack information on OTCs, vitamins, and herbal products. Many vitamins can affect the absorption of drugs and many herbal products can interact with prescription medications. For example,

A patient starts taking two herbal products, Gingko biloba and St. John's wort, but neither product is added to the patient's medication list. The physician renews the patient's prescriptions for warfarin and fluoxetine. Taking gingko with wafarin increases the patient's bleeding risk. Since gingko doesn't appear on the medication list, the physician is unaware of this drug-herb interaction. Also, St. John's wort and fluoxetine both help with depression symptoms. Taking both products means an increase in treatment effect but also an increase in side effects such as nausea, vomiting, anxiety, and insomnia. Since St. John's wort isn't on the medication list, the physician is unaware of this duplicate product interaction.

Table 4: Complete prescription medication list
Prescription medication names, doses, and frequencies
Dates of last refills and number of refills given
Medication allergies and resulting reactions
Names and phone numbers of pharmacies

Documentation prevention strategy #2 – OTCs, vitamins, and herbal products

Complete medication lists include OTCs, vitamins, and herbal products. Including these non-prescription products is very important since a recent report shows over 44 million Americans use herbal remedies and 106 million use vitamins.[2] An accurate medication list ensures safer medication orders and safer hand-offs to other providers. This brings us to a third documentation error, lack of medication reconciliation.

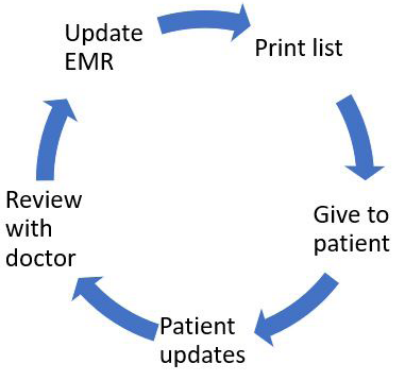
Documentation error #3 – Lack of medication review

Medication reconciliation is a process of reviewing a patient's medication list each time the patient moves to a different level of service.[13] In a hospital setting, for example, a patient's medication list is reviewed when (s)he moves from ICU to a general medical floor. The reviewer determines which medications can be stopped, such as IVs, and which ones need to be started, such as resuming home medications.This same process should be completed in the ambulatory setting; whether the patient is returning from the hospital to his/her primary care provider or

is going from the primary care provider to a specialist. And in the ambulatory care setting, the review should involve the patient.

Documentation prevention strategy #3 – Medication reconciliation

Diagram 4: Process of medication reconciliation



An example of a best practice for medication reconciliation is from an ambulatory oncology practice. Starting at the upper right side of Diagram 4, "Print list", the patient's medication list is printed from the electronic medical record during chart preparation for the coming day. Moving along the diagram clock-wise to "Give to patient", when the patient checks-in (s)he is handed the printed list of medications and allergies. While waiting, the "Patient updates" the information; either by crossing out incorrect data or writing in new data. During the office appointment, the patient "Reviews" this information with the clinician. In the final step, "Update EMR" the clinician updates the information in the patient's chart. Of the 338 patients involved in this process during the 4 month pilot, 274 (81%) patients caught at least one error or omission on their medication list.[14] This pilot demonstrates that medication reconciliation is important in ambulatory care and demonstrates a way to incorporate it in any office setting.

Dispensing

Dispensing is a term most often associated with a pharmacy; not a physician's office. However, this next error classification makes more sense when you think of "dispensing" sample medications. Legally, a sample medication is considered a "complimentary starter dose" to be used to trial a medication before filling a prescription.[15] However, sample medications are often used by patients on a monthly basis instead of filling a prescription at the pharmacy. When used in this capacity sample medications are viewed under a dispensing function and you start to understand why this error is ranked fourth in the survey of family physicians and office staff.[8] Just like a pharmacy, an office that dispenses samples should ensure medications are labeled, available for patients, and disposed of correctly.

Dispensing error #1 – Mismanagement of samples

Can you imagine if you picked up your medication from a pharmacy and there wasn't a label on the bottle? How would you know what it was, how to take it, or who prescribed it? You can apply the same questions to sample medications

without a label; especially how to take it.

Dispensing prevention strategy #1 – Medication label

A simple and safe solution for dispensing samples is to create a medication label and use it every time. The medication label should include the office name, address and phone number so the patient knows whom to contact if there is a question or problem. The patient's name and date show whom the drug is indicated, especially important when multiple family members get sample medications. The drug name, dose, route, and frequency; along with the amount dispensed and the physician's name should also be on the label. The label can be set up with blank lines that are completed by staff at the time of dispensing. Labeling sample medications before the patient leaves the office ensures that (s)he has the information necessary to take the medication safely and eliminates one type of dispensing error.

Diagram 5: Example of a medication label

Office name, Address, City, State, Zip, Phone

Patient name _____ Date _____

Drug name _____ Dose _____

Directions for use _____

Quantity _____ Expiration date _____

Prescriber name _____

Dispensing error #2 – Staff use of samples

Most sample closets are unregulated; left unlocked throughout the day to help with efficient workflow for patient care. If sample closets are left unlocked then the office needs to create safe practices around sample closet use. For example, staff members often take sample mediations from the closet for themselves, family members, and friends. These staff people feel they save money and time by not going to the pharmacy. However, this practice is not only unsafe but also illegal.

Dispensing prevention strategy #2 – Patients only

While the sample closet does offer a convenience to staff it is not appropriate for staff to dispense medications to themselves. It is also not appropriate or legal for a staff member to receive samples from the office (s)he works at if it is not his/her

personal physician. Only a patient's physician, according to Michigan pharmacy law, can provide a patient with a medication starter pack or sample.[15] Therefore, the first safe office practice is to restrict dispensing sample medications to patients only. If the staff person or family member is a patient of the office then the second safe practice is to have the staff person's physician retrieve the medications from the sample closet. A staff person should never get his/her sample medications. In this case, the staff member is a patient. As a patient, you would never go into your physician's sample closet.

Dispensing error #3 – Expired medications

All medications, samples, and drugs administered in the office, have expiration dates. Some medications, like antibiotics, may lose potency or become less effective when they are used after their expiration date. Other medications, like aspirin, can change into harmful products when used after the expiration date. Yet many other medications remain safe and effective after the expiration date. There is no good way to know if a medication is still safe and effective after its expiration date.

Dispensing prevention strategy #3 – Medication disposal

To ensure the integrity of all medications in the office, including sample medications, check them regularly for expired or out-dated products. A best practice is to check all medications once a month. Another best practice is to stock medications in a way that allows staff to use products before they expire. For example, an office has 20 boxes of a sample medication. Ten of the boxes have an expiration date of 2012 and ten of the boxes have an expiration date of 2013. The office should stock the boxes set to expire in 2013 behind the boxes that expire in 2012. However, there are times when medications expire. When that happens, the medications should be disposed of properly. It is no longer recommended to throw away or flush medications down the drain.[16] When disposing of expired medications, follow the steps listed in table 5 to keep people safe and the environment clean.

Table 5: SMARxT Disposal
Pour medicines into a sealable plastic bag. If the drug is a solid (pill, capsule, tablet) crush it or add water to dissolve it. Pour liquid drugs into the bag.
To the plastic bag, add kitty litter, sawdust, coffee grounds (or any material that mixes with the drug and makes it unpleasant for pets and children to eat).
Seal the plastic bag and put it in the trash.

Monitoring

The final medication error category is monitoring. As the name suggests, monitoring errors result from not following up to ensure medication safety. For example, not ordering a recheck of a patient's cholesterol after changing cholesterol medications is a monitoring error. It also includes not assessing if the patient is taking medications as instructed, called adherence, or getting refills on time, called persistence. As discussed at the beginning, lack of patient education is another common monitoring error. Monitoring errors are just as critical as the previous four medication error categories.

Monitoring error #1 – Noncompliance

Research shows that many patients do not take medications correctly (non-adherent) or regularly (non-persistent). Patients may not be able to afford their prescriptions or they may experience side effects with their medication. Another reason patients may not take their medication appropriately is a lack of understanding. It is difficult for a patient to be compliant with a medication regimen when (s)he doesn't understand what the medication is treating or how to take it. Lack of understanding is one area where physician offices can improve a patient's chances of taking medications correctly.

Monitoring prevention strategy #1 – Patient script

According to ISMP, the most common types of medication misuse include patients taking the wrong dose, taking the dose at the wrong time, and stopping medicine too soon.[2] Before a patient leaves the office with a new prescription, (s)he should know a few key items about the medication such as the name, dose, and how often to take it (see table 6).

Table 6: Five items to ensure proper medication use
Name of medication
Purpose of medication
Length of time to take medication
Dose and frequency
Common side effects

Providing patients with brief medication instructions goes a long way in preventing medication errors. A best practice is to incorporate the education at the time the prescription is written or e-prescribed. The education can be "scripted" so every patient receives the information in a consistent, structured format regardless of medication. An example of scripted education is as follows:

Mr. Jones, I am prescribing you a medicine called metopolol. It is used to lower your heart rate. This medicine will help with your heart failure so you will probably need it for the rest of your life. I want you to take 50 mg, which is one pill, once a day. Since it can make you feel a little tired when you first start taking it, I want you to take it each night at bedtime.

Monitoring error #2 – Lack of patient education

While a script is helpful for many medications, it doesn't always help with medications that have complex delivery systems. To return to the example that started this chapter, a patient doesn't receive education on how to use a new inhaled asthma medication from the physician's office or the pharmacy. The lack of education forces the patient to figure it out on his/her own, ask a friend or family member, or call back to the physician's office or pharmacy. Without education, the patient may not receive the benefit of medication or the medication could cause harm due to improper use.

Monitoring prevention strategy #2 – Handouts and demonstrations

Some medications, such as inhalers, injectables, and topical products require more patient education than a script can provide. For medications with complex delivery systems, a safe practice is to demonstrate appropriate use or provide diagrams of appropriate use. Unfortunately, most offices don't have a person available and/or knowledgeable to educate patients on all of these complex medications. But offices can utilize resources to address these patient education issues.

Written patient education handouts – Pharmaceutical companies, especially those with inhalers, injections, and other complex medications, make patient instruction sheets. For instructions not specific to a product, there are companies that develop patient educational materials. Often vendors of electronic health records partner with the companies that have patient education resources. Lastly, the internet is a great resource for patient education materials.

Request help from retail pharmacists – Physician offices can communicate a patient education need to the pharmacy as part of a prescription. For example, if a patient is receiving an inhaled asthma medication for the first time, the office can indicate on the prescription, "pharmacist to demonstrate inhaler technique with patient". This communication removes the assumption of education at both the office and pharmacy. It clearly indicates who should perform the education. Another option is to instruct the patient to, "ask the pharmacist to show you how to use this inhaler". It alerts the patient that the new medication is different than the typical "pills" (s)he is used to getting at the pharmacy.

Monitoring error #3 – Missing follow-up labs

Lastly, medications need to be monitored regularly for both safety and efficacy. For example, diuretics, like furosemide, can cause an unsafe drop in potassium levels. Therefore, patients taking diuretics should have laboratory tests at least yearly to monitor kidney function and potassium levels. Another example where monitoring is important is with cholesterol medications, like simvastatin. To make sure the medication is effective for the patient, a cholesterol profile should be assessed

at least yearly. If the cholesterol level is too high, the medication may need to be increased or changed.

Monitoring prevention strategy #3 – Standing orders

Many medications require routine laboratory monitoring; often yearly if the patient is on a stable drug and dose. Since prescriptions must be renewed yearly, it is a good time to make sure that all appropriate lab monitoring is complete. Staff can be empowered to assist with this process. A best practice is to create standing orders or clinical protocols with physician approval. Physicians select a few medication classes and indicate the required laboratory monitoring. When a patient calls the office for a refill request, staff checks the patient's chart for the labs pre-specified by the physician. If the patient hasn't had the laboratory tests done within the past year, staff order the appropriate tests and instructs the patient to complete the tests. This process should be reviewed and updated at least yearly to ensure continued safety.

Conclusion

Medication safety issues are a growing concern in ambulatory care; especially with the high volume of prescriptions filled each year. These errors are a result of high utilization, multi-step processes, time shortage, and information overload. In all of the above prevention strategies, the answer to safe medication use is in the development of office processes and systems, and not blaming people. The only way to make changes to office practice is to have a method of detecting medication errors. Creating a blame-free environment where staff feels comfortable reporting errors is vital. Let the staff know that the office takes errors seriously to improve systems. Make error discussions part of your staff meetings. Get input from staff on ways to improve processes. Unless an error is detected and documented, there is no way to assess the reason for the error and determine a system to prevent the error from occurring again.

The following is a recap of the safety issues and prevention strategies discussed.

PRESCRIBING Factors:

Overwhelming product selection	→	Preference lists
Look-alike name confusion	→	Tall MAN lettering
Overriding safety alerts	→	Awareness

ADMINISTRATION Errors:

Incomplete verbal orders	→	Written documentation
Unconfined drug and dose	→	Double-check system
Lack of responsible person	→	Single person administration

DOCUMENTATION Errors:

Incomplete medication list	→	Complete information
Missing non-prescription products	→	OTC's, vitamins, and herbal products
Lack of medication review	→	Medication disposal

DISPENSING Errors:

Mis-management of samples	→	Medication label
Staff use of samples	→	Patients only
Expired medications	→	Medication disposal

MONITORING Errors:

Noncompliance	→	Patient script
Lack of patient education	→	Handouts and demonstrations
Missing follow-up labs	→	Standing orders

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#6: Privacy and Confidentiality

Privacy and confidentiality are of great importance in the physician practice and requires adequate education be provided to all staff regarding their responsibilities to protect a patient's health information. Each employee should be required to sign an agreement that they understand the requirements under HIPAA and that they understand the ramifications including immediate termination of employment if they breach patient confidentiality. Breaches of HIPAA are not covered under MPIE coverage policies. MPIE may assist with referring the practice to an attorney that specializes in these cases. The penalties and fines that may be imposed by the government, as well as any civil action, may be the responsibility of the practice. This section is an **overview** and is in no way intended to be comprehensive coverage of the HIPPA regulations; each practice must devote the time to acquire the needed knowledge to ensure compliance with HIPAA.

Resource: Sample Employee Confidentiality Agreement

HIPAA

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. This law was passed to promote more standardization and efficiency in the health care industry. There are four parts to HIPAA's Administrative Simplification:

- Electronic Transaction and Code Sets Standards requirements
- Privacy requirements
- Security requirements
- National Identifier requirements

The HIPAA Privacy Rule for the first time creates national standards to protect individuals' medical records and other personal health information. It gives patients more control over their health information.

It sets boundaries on the use and release of health records. It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information. It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patients' privacy rights. Also, it strikes a balance when public responsibility supports disclosure of some forms of data – for example, to protect public health.

HIPAA Requirements for Healthcare Providers

- Provide information to patients about their privacy and how their health

information will be used and disclosed.
- Implement privacy procedures for the practice.
- Train employees in the practice's privacy procedures.
- Designate a staff member to be responsible for ensuring processes are followed.
- Secure patient records to restrict access to individually identifiable health information.
- Provide a history for non-routine disclosures to patients, if requested.
- Obtain patient consent before sharing the patient's information for treatment, payment, and healthcare operations.
- Obtain separate patient authorization for non-routine disclosures and non-healthcare purposes.
- The economic stimulus legislation 2009, prescribes bonuses for doctors who acquire electronic health records, but it also includes stringent new regulations that require practices to alert patients of information security breaches.
- The additional rules obligate physicians to individually notify patients and the local media if there has been a security breach of "protected health information," such as theft of a laptop or computer hard drive containing patient information.
- The HIPAA expansion also affects companies physicians may work with, such as coders and billers, and requires those companies to disclose security breaches to their physician customers.

Penalties for Noncompliance

Failure to comply with the HIPAA privacy provisions is not an option for physician practices. The law provides a full range of penalties. The context in which the violation occurred and the presumed intent govern the type and amount of the penalty. Physicians who knowingly release information can face stiff fines, criminal action and place their licenses at risk. According to the Privacy Rule, the penalty for a single offense of one requirement is up to a $100 fine per person, per violation, per year with a maximum yearly penalty for a single offense of $25,000. Penalties cannot be imposed if the failure to comply stems from reasonable actions rather than willful negligence. However, you may have to spend a lot of time and money proving "reasonable action."

Implementing HIPAA Compliance

Most practices already have some confidentiality protection measures in place, and many have written policies and procedures describing how staff should handle confidential issues. Most states have privacy-like laws for the healthcare industry. The only difference now is you'll be federally regulated to protect patient information

by some reasonably specific guidelines.

It is true that physician practices likely won't be held to the same standards as hospitals, but liability does lie in wait for those who don't identify potential privacy risks. Use the following strategies to jump-start your compliance efforts:

- Identify a privacy officer (this may be the office manager or administrator) who will serve as the point person for your privacy compliance efforts.
- Get a group together of knowledgeable staff and brainstorm all the areas impacted by the privacy regulations and where your office may be at risk of non-compliance.
- Examine your existing policies and procedures.
- Incorporate privacy issues throughout your policies, rather than in a single place.
- Develop acknowledgment of privacy practices form, authorization form and prepare your privacy statement with the assistance of counsel.
- Identify your business associates and develop contracts with the assistance of counsel.
- Educate and make staff accountable.
    - Have employees sign an agreement holding them individually responsible for the privacy of health information.
    - Educate new and existing employees regarding the need for privacy according to their specific job function and document those training sessions.
- Ongoing self-evaluation for your practice compliance plan.

Target Common Privacy Pitfalls

While assessing the need to comply with regulations for the release of written patient information, don't forget the substantial privacy risks possible simply through overheard conversations, unattended computer screens, or patient sign-in sheets.

Do a walk-through of your office to determine areas where privacy may be a problem. Areas to assess (and correct) may include:

- Appointment lists taped to counters.
- Amount of information requested on your sign-in sheets.
- Computer monitors facing traffic areas.
- Open trash or unsecured recycle bins.
- Accessibility of charts and other confidential information to vendors, cleaning service, or similar groups with access.
- Computers unattended still logged in to a database.
- Computer passwords containing an employee's name or initials.
- Unattended hand-held dictation devices.

- Employees with access to more patient information than necessary to do their job.
- Casual use of faxes and unattended fax machines.
- Easily overheard conversations.
- The practice of leaving confidential data on voicemail or an answering machine.
- And much more.

Use the areas of risk you have identified when developing your policies and procedures and when planning your training. You may well need to adjust job descriptions as you think through which employees need access to what information. It is essential to involve as many staff members and physicians in the process as possible to ensure buy-in to changes in the way you do business.

While you are not necessarily required under HIPAA to spend huge dollars on erecting new walls, purchasing new file cabinets, or complex computer security, you will need to be prepared to demonstrate your analysis and efforts to correct apparent problems. Demonstrating this may be as simple as redirecting traffic patterns in the office, having password-protected screen savers, and not leaving charts out where unauthorized individuals can access them. Some changes will likely need to be made, and you should budget for simple methods to correct many of the areas identified. As you develop your forms and contracts, it is advisable to have them reviewed by an attorney knowledgeable in the new regulations.

Resource: HIPAA information on the web: http://www.hhs.gov/ocr/hipaa/

What is a Breach and Do I Need to Report It?

Little more than one month after the HIPAA breach notification regulations became effective (September 23, 2009), covered entities (health care providers, health plans) and their business associates are struggling with the effects of these new rules. Many are asking:

- What is a breach?
- Do we have to notify in all cases, what are the exceptions?
- Whom do we notify?
- Do we have to notify the government?
- Do we have to modify our business associate agreements?
- Do we have to create, update our policies and procedures?

It is essential to learn about these issues before a breach happens. However, if a reportable breach happens, covered entities will need to know how and when to notify the Department of Health and Human Services (HHS).

In general, a breach is:

- There is a “breach.” The Rule defines “breach” to mean (subject to a few exceptions) the unauthorized acquisition, access, use, or disclosure of protected health information (“PHI”).
- The PHI is “unsecured.” The Rule defines “unsecured protected health information” to mean PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by HHS guidance.
- The breach “compromises the security of the PHI.” Under the Rule, this occurs when there is a significant risk of financial, reputational, or other harm to the individual whose PHI has been compromised.

If a practice believes a breach has occurred or is notified of a suspected breach analysis should occur.

1. Determine whether the use or disclosure of PHI violates the HIPAA Privacy Rule
2. Analyze whether there is a use or disclosure that compromises the security and privacy of PHI
3. Assess Whether any Exceptions to the Breach Definition Apply

If the analysis shows a breach to have occurred notification requirements must be followed. Depending on when the breach was discovered and how many patients are affected the breach notification requirements may differ. In general breach notification requirements may include:

- **Notification to Individuals**-using required notification no later than 60 days from breach discovery. The Act and the Rule specify the content requirements and the methodology required for providing such a breach
- **Notification to Media**-breach of more than 500 residents of a state or jurisdiction
- **Notification to HHS**-breach of more than 500 residents regardless of state or jurisdiction. Less than 500 the practice must maintain an internal log of such breaches and annually submit the log to HHS.
- **Notification by a Business Associate**-if breach occurs by a BA they are required to notify you so you may follow notification requirements.
- **Delay Required by Law Enforcement**-notification may be delayed if it would impede a criminal investigation or cause damage to national security.

For breaches involving 500 or more individuals, the covered entity must notify HHS at the same time as the affected individuals. For breaches involving fewer than 500 individuals, the covered entity must maintain a log of the breaches during the calendar year and report them to the Secretary within 60 days following the end of that year. HHS established a website for reporting breaches, with separate links for

immediate and annual notifications. Note that in addition to gathering information specific to the breach, both forms ask about the safeguards in place before the breach and steps taken following the breach. Also, the instructions require covered entities to complete a separate online form for each breach.
Remember: Breaches triggering a notification requirement under HIPAA also may require notice under state law, including notice to specified state agencies and officials.

Resources:
HIPAA resource-Frequently Asked Questions http://www.hhs.gov/ocr/hipaa/
HHS http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html

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#7: Claims Management

Elements of Malpractice

Understanding the concepts or aspects of medical malpractice is a vital part of avoiding a malpractice claim or suit. "Malpractice," a term implying professional negligence, is defined as the "failure to exercise the same degree of skill and learning that others with the same background and training would ordinarily exercise in the same or similar circumstances." In other words, medical malpractice is the failure to practice medicine within a range of accepted standards of care followed by one's peers.

For a claim of "malpractice" to be proven, there are four elements that must be established:

Duty
The element of duty is established by showing that a physician-patient relationship existed and therefore, the physician had a duty to care for the patient. Formerly, a relationship only existed after the physician had seen, cared for, and billed the patient. This element is somewhat complicated in the current medical-legal environment where courts often rule that a physician-patient relationship may be established through contracts with managed care entities, through on-call responsibilities in hospital bylaws, and by "curbside" consultations.

Breach of Duty
A breach of duty occurs when the physician or other healthcare practitioner failed to

comply with the applicable "standard of care" in a given situation. "Standard of care" is a legal, not a medical, phrase. It refers to the minimum accepted practice that would be exhibited by another practitioner with the same background and learning in the same or similar circumstances. It is not defined as the care provided by "most" physicians nor is it optimal care. Although standards of care are generally seen as no more than usual national or even community practices, the jury determines a particular standard from the testimony of "experts," as well as through written or published standards and the introduction of authoritative texts. Since both sides will present different versions of the applicable standards of care, it is a jury of non-physicians who will ultimately establish the standard in a given situation.

Damages

No matter how negligent the professional may have been, harm, or "damages," must be shown to have resulted from the acts or omissions of the clinician. Therefore, in addition to evaluating the standards of care, jurors will be asked to assess the degree of injury and to determine monetary damages based on the perceived injury or injuries suffered by the patient allegedly caused by substandard care. Negligence, cause, and injury must typically be proven. Injuries can be physical, emotional, or financial.

Proximate Cause

There is an important requirement of proof between cause and effect to establish a claim of malpractice. The patient may have been injured, and care may have fallen below the prevailing standard, but the poor outcome must be shown to be a direct result of negligent care. There must be an uninterrupted connection between the departure from the standard of care and the injury. For example, if an infant is born with brain damage from a solely genetic cause, the fact that a physician failed to perform a Cesarean Section in a timely fashion is not the proximate cause of the infant's brain damage. However, if the failure to timely perform a Cesarean Section was the proximate cause of some of the infant's brain damage (i.e., worsened or aggravated it); the proximate cause will be established against the physician for some injuries.

Theories of Liability

When it has been determined that malpractice has occurred, the plaintiffs will begin to identify the parties who bear liability or responsibility for the damages. There are many theories of liability. We will mention here a few of those most often discussed in claims against physicians and other healthcare practitioners.

Comparative Negligence

Comparative negligence is a theory where the percentage of fault is assessed against the individuals involved and may result in any damage awards being

apportioned among the parties. Each party is only responsible for their percentage fault of the damages.

Contributory Negligence
This term refers to conduct by the plaintiff, which falls below the reasonable person standard to which the plaintiff is required to conform for his or her protection that contributes as a legal cause to the harm he has suffered. The plaintiff's damages will be reduced, as in comparative fault, by his percentage of fault.

Direct Liability
Direct liability refers to the legal responsibility for damages caused by the professional's acts or omissions.

Joint and Several Liability
Joint and several liability is a legal doctrine in which several persons who share the liability for the plaintiff's injury can be found liable either individually (only for their percentage of fault) or together (each individual is responsible for all damages from the injury). Most states are several liability states with limited exceptions that permit joint liability.

Loss of Best Chance/Loss of Chance
Often when a delay in diagnosis is alleged, plaintiffs will assert that the delay caused the loss of the best opportunity for cure or recovery.

Vicarious Liability
Vicarious liability is the theory of legal responsibility for damages caused by the acts or omissions of another. This is often referred to with the Latin phrase Respondeat Superior, translated: "Let the master answer."

A simple example of vicarious liability is the employer's liability for the actions of his or her employees in the performance of their job duties. Physicians have liability exposure for the actions of all of their employees, not just the individuals whom they supervise in extended roles.

Other claims of vicarious liability are more complex and may, for example, arise when a physician is named as a defendant merely because he or she has, or appears to have, a business relationship with the named defendant physician.

All physicians in a group practice can be named in a medical malpractice suit even when only one of the physicians in the group cared for the patient.

Anatomy of a Lawsuit

Notice of Intent (NOI)
An NOI is a letter that describes the legal issue at hand and informs the person that

they intend on filing a suit.

Michigan law requires a mandatory 182-day notice of a lawsuit to the defendant. It's a letter detailing the allegation which gives the defendant a chance to prepare for litigation or to resolve the allegation without formal court proceedings. The formal complaint with the accompanying affidavits of merit from qualifying medical experts cannot be filed until the 182-day waiting period is up.

Complaint
The process begins with a formal written complaint. Here the plaintiff describes the acts or omissions that allegedly led to the patient's injuries. The allegations contained may be very general. A defendant must respond promptly to the allegations made in the complaint. Therefore, it is crucial to notify MPIE immediately upon receipt of the complaint so that a response may be filed within the time allowable by law.

Discovery
The process of "discovery" begins following the service of the complaint. Both plaintiff and defense attorneys must have access to all information that might be pertinent to a case (unless protected by privilege), including whatever is available to the opposing side. During the discovery phase, each attorney is permitted to "discover" such information, much of which occurs through the questioning of witnesses, including experts for and against you, in the deposition process and through written questions called interrogatories.

Trial
If the case goes to trial, the allegations will be heard by a judge and jury with a verdict rendered. A trial is a combination of intensive planning and preparation by each attorney. Our legal system permits the losing side to appeal a verdict. An appeal is not a retrial, but merely an examination of the trial court record to verify that the original trial was conducted without significant legal error. Relatively few appeals result in overturned verdicts. When a verdict is overturned, it generally results in a retrial.

Settlement
Comparatively few malpractice lawsuits reach the courtroom, and juries-ultimately decide even fewer. A decision may be made in some cases to seek settlement for an acceptable amount rather than incurring the risk of trial. Under the portion of the MPIE policy that deals with medical malpractice liability to patients, each named insured has a right to consent to settlement or to withhold consent.

Statute of Limitations

A medical malpractice action may be brought within 2 (two) years after the act or

omission that forms the basis for the claim. Alternatively, it may be brought within six months after the claimant discovers or should have discovered the existence of the claim, so long as it is brought within six years after the act or omission.

Minors have the benefit of the preceding rules. Besides, a minor's action may be brought any time before the minor's tenth birthday (or fifteenth birthday for injury to the reproductive system).

An action for wrongful death accrues on the date of the alleged wrongful act, not the date of death, and is governed by the statute of limitations that would have applied had the decedent merely been injured.

Giving a Deposition

A deposition is a testimony given under oath. A lawyer in the case will ask the deponent (witness) questions. A court reporter will record the questions and answers. The participants in a deposition typically include the deponent, counsel for each of the parties, the court reporter, and, occasionally, the parties themselves. There will be no judge present, and the deposition will typically be taken in the office of one of the attorneys.

It is imperative that you confer with your appointed counsel before the deposition. If you are not a party to the lawsuit but were involved in the care of the patient, you may also be asked or subpoenaed to testify. If subpoenaed or asked to testify, you should speak with an MPIE claims representative to help you in assessing any personal risk associated with providing testimony and whether you should contact counsel to assist you.

The importance of a deposition to the outcome of a lawsuit cannot be overemphasized. The deposition is a permanent record of your testimony. Any inconsistency between your deposition testimony and your testimony at trial can be brought to the attention of the judge or jury. It is therefore critically important that you provide truthful and accurate testimony at the deposition.

While you should follow your lawyer's advice in specific deposition situations, here are some general tips and guidelines that might be helpful to keep in mind.

- **Tell the truth at all times.** If you always tell the truth, you won't need to explain inconsistencies in later testimony.
- Do not try to decide if the truth will hurt or help the case. You are required to give the facts if you have them. **Answer factually.** As a witness or a party, your sole purpose in a deposition is to give the facts as you know them.
- **Concentrate and listen to the question.** Anxiety and stress can adversely impact your ability to process the question being asked. To guard against any misunderstandings, paying particularly close attention to the question being

asked is critical.

- **Do not answer any question that you do not fully understand.** If you don't understand a question, ask the attorney to repeat or rephrase it.
- **Take time to answer.** Pausing before answering allows your attorney an opportunity to object to the question, if warranted, and also gives you time to think through your answer. If your counsel begins to speak, you should stop your answer and let your counsel finish his/or her statement.
- **Do not volunteer information.** Answer only the question that is asked. Do not volunteer facts not called for by the question. A deposition is not the appropriate time for you to tell your side of the story. Likewise, it is also not your responsibility to educate the examiner. It is only the time for you to answer the specific questions posed by the attorney taking the deposition.
- **Avoid thinking out loud.** Unless specifically asked to do so, explaining your thought processes as to how you reached the answer is inappropriate. Similarly, do not explain or justify your answers. Once you have answered the question asked, stop talking.
- **"I don't know" may be the right answer.** Never state facts that you don't know, even if you feel that you should know the answer. If you don't know the answer, say so. Also, **do not guess.** A guess or an estimate is almost always wrong, and the opposing counsel will be able to use that incorrect answer against you. There are also times you may not remember certain circumstances or situations. In such cases, "I don't remember" may be the right answer.
- **Recognize red flags.** Leading questions that start with phrases such as "Isn't it correct?" "Wouldn't you agree" should be considered and answered with extra care. They are frequently attempting to put words in your mouth. If the attorney insists upon a "yes" or "no" answer to one of these questions, but it is impossible to answer it that way, politely say so.
- **Speak up and clearly.** This makes it easier for the court reporter that is recording everything. It also displays self-confidence. Remember that you are judged by how you speak and present yourself. Avoid nervous habits such as rattling keys in pockets, fidgeting with jewelry, or chewing gum. Your hands should be kept away from your face, and you should look directly at the examining attorney when answering. Dress in conservative clothes for the deposition.
- **Be courteous, serious, and respectful.** No matter what the attitude or manner of the examining attorney, **be sure to remain calm, factual, and unemotional.** If you allow the examining attorney to provoke you, you may find yourself saying things you later regret and could also damage your credibility. Do not let yourself be drawn into an argument.

- **Avoid superlatives such as "always" or "never."**
- **Avoid sarcasm, attempts at humor, and the use of medical euphemisms** as they can easily be misinterpreted by persons listening to or reading your deposition transcript.
- **There is no such thing as "off the record.**" Statements made or discussions over-heard at any time during the deposition can be used at the deposition. If you want to talk privately with your attorney, use recesses in the deposition.
- **Don't look to your lawyer for guidance in answering a question.** No one can testify for you. If you are looking to your lawyer for help in answering questions, your credibility will come under suspicion.
- State of Mind. Beware of questions that ask you to speculate as to what someone else was thinking or why they acted in a particular manner. You may be asked for "an explanation" for what someone else said or did. **You should generally not speculate on why someone else may have done something.**
- **Avoid Unintended Opinions.** Many attorneys will not use the phrase "standard of care," but will use other words that mean the same such as what the physician "should" have done, or what "good practice" or "reasonable practice" requires. Be aware that such questions are often seeking an opinion from you on what the standard of care is, and perhaps indirectly whether you or another healthcare provider have breached it. You should be clear as to whether or not you intend to express opinions on this subject.
- **Be cautious in responding to hypothetical questions** in which some facts are provided, and you are requested to give a response. The facts provided by the examiner may not accurately reflect the facts of the case at hand. Your counsel may provide specific guidance as to whether to respond to such questions.
- "Authoritative" has a specific connotation. In most states, if you agree that a standard text or an article is either "authoritative" or "reasonably reliable," statements contained in the publication can be read to the jury to impeach or contradict any testimony you or others may give on the applicable subject. As many texts and articles contain the opinions of the authors with whom, if you reviewed the entire publication, you might agree, disagree or upon which you have no comment, **be careful when considering whether a particular text or article is in fact "authoritative" or "reliable."**
- Anything is possible. Any opinions expressed should be to "medical probability." You may be questioned about theories of liability, causation, or damages that are remotely possible, but not probable. **Keep in mind the difference between possibility and probability.**

- Remember that no one is perfect, and **witnesses do make mistakes** in depositions. **The key is not to become upset if you've made one.** Just advise your counsel as soon as you realize your mistake. Your attorney can help you correct inadvertent errors.

Assisting Your Patient's Attorney

What if your patient is involved in litigation against another party, perhaps in an accident or disability dispute, and asks you to support them? Generally, a treating physician must assist a patient in litigation where the patient's condition becomes an issue. This duty is usually fulfilled by supplying copies of medical reports and records upon request and by complying with any subpoenas to appear for a deposition or a trial. The duty does not generally encompass an obligation to meet with the patient's attorney. However, we recommend a conference between a healthcare provider and the patient's attorney before any depositions, trials, or other procedures. Thus, you may choose to make yourself available for an informal, pretrial meeting with the attorney or patient, without the need for a subpoena.

Risk Management Strategies

If you would like to assist your patient by meeting informally with his attorney, but are concerned about being drawn into the dispute, remember some simple precautions that can reduce your risk.

- The meeting is fully "discoverable," which means you may have to testify concerning the conversation. **Nothing is "off the record."** You also need a signed release from the patient to release your records and to discuss your care of the patient.
- **Be cautious.** Always remember, no matter how friendly and no matter how conversational the approach, the patient's attorney is there to gain information, not to become your friend.
- It is preferable that the meeting is held somewhere other than your office. This decreases the amount of personal information the attorney may glean about you. A staff lounge or some more neutral area is a good choice. Schedule a limited amount of time and have someone interrupt at a prearranged time.
- **Listen carefully to questions before responding.** Answer truthfully and answer only the question specifically asked. Avoid editorializing or volunteering information. Simple answers such as "yes," "no," and "I have no opinion" may be used where appropriate. You may decline to testify unless subpoenaed. In any case, you will want to clarify your role in the action. The attorney may intend to call you as a "fact" witness to comment mainly on your care and the course of the patient under your care. You may also be asked to speculate on the patient's prognosis or to give opinions outside the scope of

your specialty.

- **Clarify your role.** Many times an attorney will ask you to disclose your opinions of the care of other physicians. Commenting on any area besides your involvement in the patient's care as reflected in your records, in effect, makes you assume the role of "expert witness." That role is entirely voluntary. Even if subpoenaed, you cannot be forced to give opinions outside the scope of your role in the patient's care. For instance, you may not be willing to become the "expert witness," electing to confine your comments to your care and observations.
- **Don't be pressured.** If at any time you feel uncomfortable with the direction of the conversation, you may terminate the meeting without the need for explanation. "I believe that's all I have to say." You may want to call MPIE for further advice after the attorney has left the office.

Summary of Medical Malpractice Law

Much of Michigan law on medical malpractice is codified at Mich. Comp. Laws Ann. §§ 600.2913 through 600.2912h (West 2000). Subjects covered include the elements of a malpractice action, a compulsory procedure for notice and discovery before filing suit, and affidavits of merit. The legislature made significant changes to the laws of medical malpractice effective April 1, 1994, so the information in the section addresses actions occurring after that date. Michigan laws can be searched on the web at Michigan Legislature (http://www.legislature.mi.gov).

Reporting Unexpected Outcomes/Incidents

Duties and Responsibilities of the Insured for Reporting

It is essential to report a potential claim before it becomes an actual claim or lawsuit. Such notice to the company allows us the opportunity to investigate serious problems when memories are fresh. Often early reporting of potential claims, or "incidents," can make all the difference in MPIE's ability to evaluate and defend actions initiated against our providers.

Examples of events that signal early warnings and may indicate contact to MPIE:

- **Dissatisfaction**—a direct or indirect expression of displeasure by either a patient or a patient's family member about the care received that carries a threat potential for litigation.
- **Notification of a Patient Complaint**—any notice from your local medical society or other organization concerning a patient report or complaint about your treatment.
- **Requests for Copy of Records**—a written or verbal request by a patient's attorney, copy service, or the patient where there is a concern of potential litigation.

- **Unexpected Outcomes or Incidents**—Early notification is always best as it allows the claims management staff to work closely with the physician and patient to resolve concerns while the incident is still fresh.
- **Medical-Legal Situation**—any situation in which a potential claim could be avoided with your appropriate action or response.

The insured physician is **required to report** a potential claim which includes any medical incident that may result in a written notice, demand for compensation, or lawsuit indicated by the receipt of a Notice of Intent (NOI) or Summons & Complaint. Reporting preserves coverage even if the claim is not made until years later. That is because the policy covers claims and potential claims reported to the company and committed to writing while the policy is in force.

Beware the pitfalls for the unwary insured who believes somebody else involved in the medical incident has reported a claim or potential claim. Such a report by others is not enough to secure your coverage. **It is essential that each insured involved in a potential claim take the time to report it to the company.** The policy defines a reported claim or potential claim as a notice by the policyholder to the company that has been committed to writing. Thus, notice by another insured is not noticed by you, and you may forfeit your right to coverage by not following this requirement of your coverage agreement.

Resource: How to Report a Claim to MPIE

FAQs About Subpoenas

How do I know a subpoena is legitimate?
Subpoenas are issued for a variety of reasons and in many contexts. The most common uses relate to the production of records or the appearance of a witness at a trial or hearing. Only subpoenas with an “authorized signature” by an “attorney of record,” the clerk of the court, or a judge are valid and enforceable. An “authorized signature” can be written by hand, stamped, typed, photographed, or lithographed. The subpoena must be imprinted with the Seal of the Supreme Court of Michigan, provide the case number assigned by the state and the Court’s location, set forth the date, time, and place of the hearing and the title of the action, and state that a failure to comply may subject the recipient to penalties for contempt of court. If it contains these elements, it is presumptively valid and must be complied with.
If you receive a subpoena that is questionable in any way, please contact MPIE Risk Management.

What if I’m subpoenaed to appear at a trial or hearing?
The law requires that the signer of a subpoena provide “reasonable notice” of the date and time of appearance. It must be served “at least two days” before the

witness is to appear. A failure to comply with the subpoena may be considered contempt of court. The party issuing the subpoena must take “reasonable steps” to keep the witness informed of adjournments or changes in the hearing or trial schedule. If the served witness notifies the party that it is “impossible” for the witness to be in Court as directed, the party must either excuse the witness from attendance at that time or notify the witness that a special hearing may be held to adjudicate the issues.

If you are subpoenaed to testify at a trial or a hearing, you are strongly encouraged to contact your practice manager or MPIE Claims Management for assistance with any logistical or substantive concerns.

What if I am subpoenaed to testify in a civil or criminal deposition?

Health care providers are often asked to provide factual or expert testimony in both civil and criminal matters. Attorneys for any party can issue subpoenas requiring a provider to appear at a time and place of their choosing, although it has to be in the county where the witness resides. More often than not, someone from the requesting attorney’s office will first contact the provider to set up a mutually agreeable date for a proposed deposition. The testimony sought at these depositions can range from innocuous to significant in many contexts, and thus before responding to any request, there are several steps which should be considered.

- First, understand that if the initial request is ignored, it may well be followed by a subpoena with a date and time over which you have no control. The lesson here - don’t ignore the request - it probably won’t go away.
- Two, have your practice manager obtain the name of the action (criminal or civil) and the identity of all parties and their counsel.
- Three, contact MPIE Claims Management for assistance concerning whether the requested testimony may present any potential, professional liability exposure for you or other involved health care providers. Well-intentioned but unprepared testimony can (and often does) lead to devastating professional outcomes during questioning by an experienced attorney. As appropriate, we will obtain legal counsel to assist you with any potential issues surrounding your anticipated testimony and its scope.

The National Practitioner Data Bank (NPDB)

The NPDB was established under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986. NPDB is an information clearinghouse to collect and release information related to the professional competence and conduct of physicians, dentists, and other health care practitioners.

Resource: The Practitioner’s Guide to Data Banks (https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp)

Attorney requests for patient medical records: what should be released?

It all depends on whom you ask. Some office practices, on the advice of their attorney or practice consultant, release only the part of the medical record that was generated in their office during the past two or three years. MPIE, on the other hand, recommends that the complete medical record, including lab results, x-ray reports, letters, and consultations, **except legal communication,** be released. Legal documents, such as legal opinions from your attorney, letters from MPIE, peer review documents should be kept separate from the medical record.

Our opinion is based on two considerations. All of the information in the patient's medical records is available to physicians or other health providers to help them shape their medical opinions, diagnosis, and treatment options. Furthermore, under Michigan State Statute; attorneys acting on behalf of their client have a legal right to a complete set of medical records. While HIPAA regulations need to be followed in your medical record release policies, HIPAA regulations do not prohibit the release of the entire medical record. For some offices, the complete medical records are voluminous and costly to duplicate. We suggest that office practices charge a reasonable but adequate fee for their medical record release services.

Unfortunately, MPIE has been in lawsuits in which the initial request by an attorney for the complete set of medical records was not followed. This led plaintiff attorneys to allege a cover-up by the physician and incompetent medical office practices. While the medical record release procedure may not have altered the final settlement of these cases, the cost of defense increased. Should you have any questions about medical record release to attorneys, please contact MPIE at (616) 202-2288, ext. 1.

Disclosure Skills

Your Patient Has an Adverse Outcome: What Now?

One certainty in the practice of medicine is that there will always be a percentage of cases where treatment does not result in the perfect outcome. Regardless of the clinical expertise of the provider, adverse outcomes and unexpected results can and do occur. Most often, these events are not the result of substandard care or malpractice but are the known potential risks or complications associated with the procedure, test, or treatment.

Patients have high expectations and are understandably disappointed when adverse outcomes are the result. However, a claim or lawsuit is not the predestined result of a complication with care. Experience has shown that how the provider responds to the event has the most significant impact on whether the matter will result in a claim. The following tips are offered to assist providers in dealing successfully with patients who have experienced a less-than-perfect result:

Communicate
As soon as possible, fully inform the patient of the complication using language the patient understands.

Provide a basic outline of what has occurred, avoiding overly technical medical terminology. Certainly, communicating this information to the patient is much easier if proper informed consent was obtained before treatment. Good informed consent allows the physician to open the conversation with a statement such as "Well, unfortunately, one of the potential complications we discussed did occur…. Now, this is where we go from here…."

Be open and available
Do not avoid the patient or the patient's family members. Avoiding difficult situations is a natural human reaction, and sharing bad news about an adverse outcome or complication in treatment is difficult. It is equally true that the patient's *actual* reaction is typically much better than the *anticipated* one. With a proper explanation, patients can understand and accept that adverse outcomes do occur.

What they do not accept is poor communication. A physician who communicates poorly after an adverse outcome is typically seen as uncaring, and it is the primary reason patients pursue the legal option. Patients want answers and often feel that litigation is their only recourse.

Express your concern
Demonstrate your empathy and concern for the patient. Where circumstances warrant, and after due reflection, an apology may be appropriate. Your outward expressions of care and concern are significant to the patient and can strengthen the physician-patient relationship. Many patients have more confidence in their providers after working through such an event—because their providers demonstrated care and concern.

Do not blame others
Do not point fingers at others involved in the patient's care. Despite your concerns regarding another provider's treatment, consider whether it is fair and professional to critique another's treatment without knowing all the circumstances the provider faced. Follow established procedures for quality improvement and peer review when you have such concerns. Remember, it is never useful to place blame or incite the patient. Doing so usually results in a distrustful patient and a lawsuit rather than a patient ready and willing to focus on treatment for the complication.

Present a plan
Outline for the patient your plan for continued treatment in the near and long term. Let the patient know you have thoroughly considered all relevant options and have a detailed plan if additional treatment is necessary.

Does the patient understand?
After your presentation, question your patient on the key points. Be confident he or she has a clear understanding of what has occurred and what the future course of action entails.

Document
Document your conversations with the patient and family members, their response to the information, and the agreed-upon (or proposed) plan of action.

Give us a call! If you are concerned about a particular situation, please contact us to discuss it. We are here to help, and we appreciate the opportunity to assist you.

Steps in Dealing with an Unanticipated Event

1. Identify the incident and care for the patient/family.
    - Initially, state known facts, express empathy, concern, and reassurance about care and follow-up.
2. Investigate the incident.
    - Determine facts, impact on the patient, care plan (family's immediate and long-term needs—emotional, economic, and practical).
    - Contact MPIE.
3. Plan/coordinate/practice the apology.
    - Decide who should attend (patient, family members).
    - Make it a team effort (attending MD, risk manager, medical director, and social worker, others as appropriate).
    - Develop an action plan regarding future treatment/compensation.
    - Consider the best setting for privacy and comfort.
4. Meet with the patient/family.
    - Disclose the facts in lay terms.
    - Acknowledge responsibility (when appropriate).
    - Apologize—show remorse/sorrow.
    - Avoid excuses and blame.
    - Explain how recurrences will be prevented.
    - Discuss the plan of action.
    - Elicit responses—and listen.
    - Be sure all patient/family concerns are addressed.
5. Provide ongoing follow-up for all involved.
    - Inform patient of investigation results and corrective action plan.
    - Maintain continuous contact.
    - Check-in with providers involved in the incident.
    - Debrief with your office staff.
    - Implement corrective action.

Remember to document objectively each discussion, who participated, and critical issues.

The other half of the equation—you and your medical team

1. Acknowledge your emotions.
    - Remember that it is common to feel guilt, anxiety, depression, loss of concentration, and fear of consequences.
2. Share your feelings with family and friends.
    - Keep patient information confidential.
3. Debrief with the care team involved in the event.
    - Lead an open, blameless discussion.
    - Focus on systems rather than individuals.
    - Foster an atmosphere of caring/compassion.
    - Offer peer support and counseling.
    - Offer training and coaching for prevention.
    - Implement patient safety training.
4. Seek support through risk management professionals, books, workshops, or private counseling.
5. Be attentive to diet, exercise, and rest.
6. Use relaxation techniques, such as deep breathing.

Please contact our Risk Management or Claims Department personnel for advice or assistance.

Apology: The Right Thing to Do

In this day and age, with physicians feeling besieged by malpractice claims and the fear of litigation, many physicians firmly believe that apologizing for an adverse outcome in care is equivalent to an admission of guilt or wrongdoing. The obvious concern is that well-intended expressions of empathy will later be used as evidence against the physicians by the very patients they were trying to console!

These same physicians naturally assume that their insurance company would not want them apologizing for a poor result or revealing information to a patient about what went wrong and why. Certainly, when actual medical errors do occur, the appropriate response should always be to be straightforward with the patient regarding all aspects of care. This applies in all circumstances, whether you are dealing with an adverse outcome or actual patient injury resulting from a medical error. The facts regarding your care are what they are. The facts will not change, and they should be shared with the patient. In short, your patients have a right to all of the information you possess relevant to their medical condition.

Our experience demonstrates that an authentic and sincere apology or expression of caring and concern over the patient's outcome has a tremendous influence in strengthening the physician-patient relationship and promoting patient trust. Importantly, this enhanced trust *dramatically reduces* the likelihood that the patient will seek answers through the financially and emotionally taxing legal system.

Most often, it is a *lack of communication* or a *physician's failure to commiserate* that makes a patient believe the physician is unconcerned. Then the patient considers ways to take control of the situation to get the physician's attention. Typically, this involves hiring a plaintiff attorney to "get some answers"—and then the misery begins!

When the physician is not immediately aware there is a problem, the chart should reflect the date of notification. Here is an example of a good chart note:
Received a call from Dr. Smith today, advising patient—now living in Holland—may have experienced complication relating to a procedure I performed 4/12/15. Records are on the way, I'll review and contact the patient.

A chart entry like the above is likely to eliminate the need for otherwise unnecessary legal wrangling relating to the question "When did the clock start?" It also simplifies statute of limitation issues.

The apology itself

A physician's sincere expression of regret following a poor outcome or distressing patient experience is a powerful means of enhancing trust. In a case where a mistake was made, the patient should be told this forthrightly, with good eye contact. Here is an example of an excellent, forthright apology:

I am very sorry this happened and that you've had to go through this ordeal. John, the medication you received was due to a prescription error on my part. It was my fault, and I feel terrible about it.

Somehow I overlooked the information you had provided about your drug allergy. It shouldn't have happened, and we're reviewing the case to make sure something like this doesn't happen again. You're going to be just fine, but it looks like you'll need to spend at least one more night in the hospital. John, do you have any questions for me?

A sincere apology and admission can prevent, rather than ignite, a lawsuit—a fact that plaintiff lawyers acknowledge. The facts do not change, and patients appreciate honesty and candor. Many lawsuits are filed because physician communication was lacking when it was needed most. Lawsuits aside, an apology is the right thing to do when things go awry, and this is true regardless of when the apology occurs.

Resources: Disclosure Toolkit and Disclosure Culture Assessment Tool

Disclosure of Adverse Events—Skills Primer

An *adverse event* is an event that results in unintended harm to a patient by an act of commission or omission rather than by the underlying disease or condition of the patient.[1]

Why Disclosure is Important

Disclosure is important to demonstrate open and transparent communication following an adverse event.[2] Disclosure of adverse events is advantageous for providers and patients. It is a necessary element for maintaining trust with the patient. It also helps support the patient and their families. Open communication with patients can also help reduce the frequency and costs of litigation. A common reason that a patient files a lawsuit after an adverse event is a breakdown in the patient-physician relationship. The patient believes that there was inadequate communication.

Disclosure Process

Disclosing an adverse event to a patient can be challenging for healthcare professionals. Planning and preparation are essential to ensuring everyone benefits. Each conversation is unique, but most will include similar components. Being familiar with them ahead of time helps when the need arises.

Initial Disclosure Conversation

As soon as an adverse event has been identified, the healthcare professional should notify the patient or the family members. The Agency for Healthcare Research and Quality (AHRQ) recommends that the conversation occurs within 60 minutes of identifying the adverse event.[3] The discussion should explain that an adverse event has happened, but the discussion should be limited to only the concrete, known facts. It is important to communicate that an investigation to understand fully what occurred is underway. The results will be shared with the patient or family members. Designate a contact person within the organization. They should be available to listen and validate the patient's or families' questions or concerns and provide updates on progress. They should also express appropriate compassion and focus on the continuing needs of the individuals involved. An important note is that healthcare providers involved may need a referral to support and resiliency services.

1 https://www.ncbi.nlm.nih.gov/books/NBK216102/#:~:text=INTRODUCTION,or%20condition%20of%20the%20patient
2 https://www.ahrq.gov/patient-safety/capacity/candor/modules/guide5/notes.html#:~:text=Response%20and%20Disclosure%20is%20an,expectations%20for%20safe%2C%20quality%20care
3 https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/candor/module5/mod5-disclosure-checklist.pdf

Disclosure Communication

After the initial conversation and investigation, the team should prepare for a full apology and disclosure communication. The preparation should consider the following steps:

Get Ready

Once an adverse event has been investigated, it is essential to discuss the results with the individuals involved. Review the event details with the team and identify the best way to explain it to the patient. Discuss the goals for the disclosure conversation with the individuals that will be present for the discussion.

Set the Stage

Use a private and quiet area for the disclosure conversation with the patient or family members. Make sure they know the purpose of the discussion.

Explain the Facts

- Discuss the known details of the adverse event as contained in the medical record.
- Describe to the patient or the family members what happened in a way that is easy for them to understand.
- Explain how the adverse event happened. *Do not speculate or mention individual names.*
- Inform them of potential consequences from the adverse event. If necessary, discuss future care plans and if there will be any short or long-term impacts on the patient.

Apologize

It is important to apologize early in the conversation. Healthcare providers should be permitted to show sympathy or regret in the conversation. Below are a few examples of how to apologize to the patient or family members.

- “I am so sorry that you were harmed.”
- “We weren’t expecting this to happen—and I am sorry it happened to you.”

Listen and Empathize

Ensure that the patient or the family members understand what happened and address any concerns. It is essential to listen to the patient or family members and acknowledge their feelings.

Closing the Discussion

When completing the discussion, discuss the next steps and plan a follow-up

conversation, if necessary. Inform the patient or family of things being done to prevent adverse events from happening to other patients.

Documentation
Following the discussion, document an accurate accounting of what happened in the medical record. Capture the facts of the conversation and the follow-up plans established. If you have questions about what to document, seek guidance from risk management.

Debrief
After the disclosure with the patient or family members, debrief with the team involved on how it went. Try to identify what changes can be made, or other things that can be done to prevent similar adverse events from occurring.

An Apology is not an Admission of Liability

When a healthcare professional apologizes after an adverse event, it does not mean that the healthcare professional accepts liability. Many states have protections in place that encourage healthcare providers to hold apology and disclosure conversations by preventing those statements from being used against the provider in a medical malpractice action. Here are a couple of examples.

Michigan Law (MCL 600.2155)

> A statement, writing, or action that expresses sympathy, compassion, commiseration, or a general sense of benevolence relating to the pain, suffering, or death of an individual and that is made to that individual or to the individual's family is inadmissible as evidence of an admission of liability in an action for medical malpractice.

Ohio Law (ORC 2317.43)

> In any civil action brought by an alleged victim of an unanticipated outcome of medical care or in any arbitration proceeding related to such a civil action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, error, fault, or a general sense of benevolence that are made by a health care provider, an employee of a health care provider, or a representative of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim, and that relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

Conclusion

Effective apology and disclosure procedures allow physicians and healthcare providers to exhibit their integrity and humanity in the face of difficult situations. These conversations provide some much-needed closure to their patients and families. Reducing the stress and anger of the situation also leads to less costly litigation. Following these fundamental risk management principles often achieves the best possible outcome.

After an adverse event at your facility, please contact the MPIE Claims Department as soon as possible at claimintake@mpie.org or 616-202-1799.

Additional resources:

Visit the MPIE website to listen to the following webinars:

- Disclosure: Effectively Handling Adverse Events
- Disclosure, Apology, Candor

AHRQ Communication and Optimal Resolution Toolkit

Institute for Healthcare Improvement: Shining a Light: Safer Health Care Through Transparency

Health Affairs: Communication-and-resolution programs: the challenges and lessons learned from six early adopters

Journal of the American Osteopathic Association: Efficacy of a Physician's Words of Empathy: An Overview of State Apology Laws

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Patient Billing/Collections

There are bountiful risk-related issues surrounding the patient billing and collections process. Most of these risks involve allegations of fraud and abuse-related miss-doings. Actions against physicians or their staff related to fraud and abuse do not fall under the scope or coverage of your professional liability policy, therefore we will not focus on them. Rather, we will focus on best practices around the billing and collections process that can minimize the potential of pushing an unsatisfied patient into a claimant.

Robbery/Embezzlement

In the event of an attempted robbery (cash or drugs), a conservative approach is best. Cooperate with the requests of the intruder. Resistance should not be attempted. Have a plan in the event of violence or threat as part of your emergency preparedness plans. Staff should practice roles in the event of this scenario so all know their place and actions.

While few embezzlement cases in medical practices occur on large scale, they do occur on a regular basis. Medical practices are vulnerable because they are mostly a cash business and physicians are focused on patient care rather than bookkeeping. Cash, incoming checks, and payroll represent the three areas most susceptible to embezzlement.

Michigan Group Management Association (MGMA) conducted a study in 2010, to determine the types of embezzlement schemes and the nature of fraud committed in medical groups. The most prevalent types of fraud reported were:

- Taking cash from the daily deposits
- Paying personal bills with company funds via checks or credit cards
- Adding hours to paychecks or adjusting pay rates (or the hours/pay rates of friends and family)

To prevent embezzlement we recommend that controls and double-checks be in place below is a list to consider:

Internal controls that should be in place include:

- Employee Screens
- Obtain criminal background checks including a credit report before hiring.
- Cross-train and separate duties-smaller practices may require an accountant or physician to oversee random transactions.

- Create a list of who handles cash, routinely verify petty cash balances, keep the balance small and put one person in charge of the account.
- Require that staff who take cash payments write receipts. Post a sign at the counter reminding patients to ask for a receipt.
- Balance receipts daily and have a second person verify.

Office Procedures

- Insist that every transaction be recorded to create a paper trail.
- Reconcile receivables and charges daily.
- Watch for unusual inventory purchases or an increase in purchases.
- Randomly verify vendors.
- Track expense trends and compare to previous years to spot unexpected increases.
- Examine payroll expenses, write-offs, adjustments, refunds.
- Investigate patient complaints about account balances.
- Conduct outside audits periodically.

Banking Procedures

- Checks should be stamped “For Deposit Only” immediately and deposited daily. Keep duplicates of all deposit slips.
- Physicians should rotate weekly the duty to sign checks. Never sign blank checks.
- Store checks in a secure place and issue checks only from invoices.
- Use a staff member that is different from the one who writes checks to reconcile bank statements each month. Compare payments received to bank statements and the general ledger.

Red Flags

- Often the embezzler will be described using terms such as: “long-time” and “trusted” employee. Embezzlers often give themselves away in their behaviors. Some tip-offs that employees may be stealing include: employees who appear to live beyond their means, employees who won’t go on vacation, employees who are not team players, more patient complaints about billing mistakes, employees who have unusually close relationships with vendors-kickbacks could be involved.

In the event embezzlement is uncovered or suspected, a thorough investigation is required. Avoid accusing an employee until you know the facts; contact your attorney or CPA for advice first. Embezzlement can happen in the usual way and creative ways, so the physician/practice manager must always remain vigilant and build in double checks that ensure it is identified early. Your professional liability insurance does not cover you for this type of loss.

Scheduling

Developing good relationships with patients starts the moment they step into the reception room. Most patients expect to wait; however, they do not want to wait long. Studies have shown that increased wait times, particularly over about one-half hour, are associated with a dramatic increase in the percentage of dissatisfied patients.

An efficiently run practice requires that physicians and office staff time be maximized, factoring in time for unforeseen delays and emergencies. With careful planning, the office scheduling system can maximize patient satisfaction as well as the use of the physician's time.

The following are keys to effective scheduling:

- Identify reasons for the appointment so that adequate time is allotted.
- At the time of the initial phone call for appointment, always obtain two phone numbers where the new patient can be reached. Always verify return patients' phone numbers where they can be reached.
- Know the patient. If an individual has a history of longer than average appointments, that patient should be scheduled for more time.
- Avoid double booking.
- Make allowances for emergencies. Well-positioned gaps in the appointment book can help keep the schedule running smoothly. If a delay does occur, after verification with the physician, communicate the delay to the patients and be specific about the length of the delay. Allow patients the option to reschedule the appointment.
- For patients who are on a tight schedule, offer the first or last appointment, or a lunchtime appointment and instruct them to call beforehand to check how the schedule is moving.
- A cancellation or postponement should be noted in the patient's chart. Appointments canceled or postponed by the physician should be tracked in the computer system if possible and rescheduled after ensuring that the case is not an emergency, following verification with the physician.
- Avoid physician interference with the patient appointment system. Doctors should ask patients to call for an appointment. This allows staff to fit them into the schedule at the most opportune times.
- Consider patient needs for appointment times that may include evenings or weekend appointments.
- Make the reception room a pleasant environment. Offer educational reading material on medicines and health as well as a good assortment of up-to-date popular magazines. If your patient is Spanish speaking, you may want to include patient information, magazines, etc. in Spanish.
- Record the arrival time for each patient on the record so the physician can

monitor the waiting time. Give the patient an expectation of how long they might be waiting for the doctor. A sign in the waiting room telling patients to notify the receptionist if waiting more than 30 minutes is a good idea.

- Remember that a patient waiting in an examining room is still waiting. Schedule to minimize waiting time there as well. Also, a comfortable environment and reading material will make the wait more pleasant.
- A courtesy is to ask the patient who has been waiting over 30 minutes if they would like to wait or be rescheduled.

No-Show Appointments

In the event a patient misses a scheduled appointment, staff should attempt to contact the patient to reschedule and determine the reason for the missed appointment. At least three attempts to reach the patient should be made; typically, two phone calls and then a follow-up letter. One of the phone calls should be made at off-hours to increase the likelihood of reaching the patient. All attempts to reach the patient should be documented in the medical record along with the date, time of call, phone number called, address where letter was sent, the reason for the missed appointment, and the outcome (e.g. left voicemail, no answer, rescheduled appointment). If a patient fails to reschedule or is unable to be reached to reschedule, the physician should be notified. The same no-show procedure must be applied to all patients whether they are an established patient, new patient, Medicaid patient, or ER patient. If the patient is a new patient who was referred by their Primary Care Physician, the PCP should be contacted in addition to the patient.

Implementing a no-show policy that is communicated to all patients could reduce no-show rates. The policy should include a statement that it is the patient's responsibility to cancel an appointment at least 24 hours in advance, what steps to take when a patient misses an appointment, as well as the ramifications for a specified number of missed appointments.

Patients who miss three or more appointments should be considered for termination from the practice. The reasons behind each no-show appointment should be evaluated when making the determination whether to terminate. Refer to Office Systems chapter: Terminating the Physician/Patient Relationship for further information and guidance on patient termination.

Avoiding Claims of Sexual Abuse

Chaperones for Intimate Exams

It is recommended that authorized health professionals serve as chaperones rather than office clerks or family members. Health professionals are held to standards for safeguarding patient privacy and confidentiality. Furthermore, their status affirms the formal nature of the examination. Unless specifically requested by the patient, family

members should not be used as chaperones. The physician should keep inquires and history-taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination.

There are strong positive as well as some negative reasons behind the use of chaperones during intimate exams. The positive (risk mitigating) reasons are topped by the fact that a chaperone acts as protection against and as a potential witness in the event of a criminal sexual misconduct allegation. The top negative reason cited by both physicians and patients is the impact a third party may have on the physician-patient relationship. Specifically that it may hamper communication and intensify feelings of susceptibility and embarrassment on the part of the patient. **In 1998, the American Medical Association (AMA) grappled with this issue and had wanted to deem it "unethical" not to use chaperones during intimate exams.** However, their final opinion was much softer and they concluded that the use of a chaperone is advised, but should involve input from both the patient and physician.

Because of the significant consequences that a sexual misconduct allegation can have on a physician's reputation, career, financial stability and personal life – the use of the most effective means to mitigate the risk is encouraged. **The most effective way for the physician to protect themselves is the consistent use of a chaperone for both male and female physicians during intimate exams.** However, if this practice is not possible or the physician makes the conscious decision not to employ this practice then the adoption of the practices below are strongly recommended:

- That the practice considers posting signs in each exam room offering a chaperone so that the patient is aware of this opportunity and could request a chaperone if desired.
- That the intake nurse or physician have a conversation regarding the availability of a chaperone and honor the request if made. Document this offer or put it into an office policy.
- Maintain an opportunity for the patient to have a discussion privately with the physician while they are fully clothed either before or after or both before and after the intimate exam. During the discussion period before the intimate exam, the physician is also able to access whether or not they would prefer or find the use of a chaperone necessary.

Non-Compliant Patient Behaviors

All health care providers, regardless of specialty, encounter patients who are non-compliant with medical advice or treatment recommendations. In many cases, the patients are not being deliberately non-compliant, and their providers can help them

become more compliant. Good communication skills, including active listening, are essential for good patient care and compliant behavior. A provider's choice of words, body language, and even silence all play a role in how a patient receives the provider's information and advice. A provider who appears rushed and doesn't allow a patient time to fully explain symptoms or ask questions may be setting the patient up for failure. Other factors that can lead to patient noncompliance include the following:

- Misunderstandings due to medical terminology
- Misunderstandings due to language, a hearing disability, or mental barriers
- Patient not realizing the seriousness of the condition or urgency of the situation
- Patient not having insurance coverage or money to pay for the recommended medications, tests, or treatment
- Patient believing the treatment will be embarrassing or uncomfortable
- Patient deciding to go elsewhere for treatment
- Patient simply forgetting

It is important to provide patients with enough information regarding their condition and your treatment recommendations and to provide it in a format that is easy to understand. Stressing the significance of the condition and the need for timely follow-up should help with patient compliance.

A patient certainly has the right to refuse recommended treatment or tests. You are responsible for informing the patient of any risks associated with a refusal of care and documenting this discussion in the patient's chart.

You may choose to dismiss a habitually non-compliant patient. Allowing a patient to continue non compliant behavior can not only be detrimental to the patient's health but can also increase your professional liability exposure. Any dismissal letter to the patient should include a reiteration of your treatment recommendations and the risks associated with not receiving the recommended treatment.
Generally, you can terminate your relationship with a patient at any time and for any reason.

The exceptions are that you may not stop treating a hospital inpatient, a patient in unstable condition, a pregnant patient in the third trimester (because she will have difficulty finding another provider who will take her –thus abandonment), or a number of patients from any specially protected population or socioeconomic group.

In addition, federal and state law protecting the disabled may prevent you from discharging a patient whose noncompliance is the result of a physical or psychological disorder.

Risk management strategies for combating patient non compliance

- Educate patients regarding the recommended treatment or test and why it is necessary.
- Inform patients regarding any alternatives, benefits, risks, and complications associated with the proposed treatment or test.
- Provide clear oral and written instructions to patients, using interpreters as necessary.
- Emphasize the seriousness of the condition and the urgency of the recommended treatment or test.
- Schedule referral and follow-up appointments before the patient leaves.
- Place reminder calls to patients regarding upcoming appointments.
- Follow-up on failed appointments.
- Document all non compliant behavior including no-shows, cancellations without reappointments, and failure to follow recommendations regarding treatment, diagnostic studies, referrals to specialists, medication use, etc.

It is reasonable to expect a patient to share responsibility for compliance with your follow-up recommendations. However, court decisions nationwide have placed significant responsibility for patient follow-up with the health care provider. In the event of a lawsuit, the most crucial element in your defense is documentation in the medical record indicating your instructions and advice to the patient regarding treatment recommendations, referrals, and follow-up care.

Resource: Sample Appointment Reminder Postcard, Sample Letter to Patient: Failure to Keep Appointment

Language Challenges/Interpreter Requirements

All patients are entitled to confidential, effective communication, and fully informed consent. For many healthcare providers, this means having to develop strategies for working with patients for whom English can be a challenge.

The DHHS Office of Civil Rights has concluded that inadequate interpretation for patients with Limited English Proficiency (LEP) is a form of **prohibited discrimination** on the basis of national origin under Title VI of the Civil Rights Act of 1964. Over the past few years, the Civil Rights Division of the U.S. Department of Justice has been charged with coordinating, reviewing, and enforcing rules established to ensure that LEP individuals have access to essential services. In addition to the Civil Rights Act, there are a variety of state and local laws that apply to LEP individuals including the state laws against discrimination.
One or more of these laws will require you to provide a qualified interpreter or auxiliary aids to ensure effective communication at no cost to the patient. Additionally, your ability to continue receiving federal or state reimbursement may be affected by

your compliance with these laws.

In Michigan, people with LEP are defined as individuals with limited ability or an inability to speak, read, or write English well enough to understand and communicate effectively in normal daily activities. The patient decides whether he/she is limited in his/her ability to speak, read, or write English. **This includes people whose primary language is not English as well as those who may have hearing, sight, and speech limitations.**

LEP Q and A:

Who decides what aid is necessary?
While the patient decides whether he or she is limited in his or her ability to speak, read, or write English, the provider, in consultation with the patient or patient's representative, determines what strategies are necessary to communicate effectively.

If an interpreter is not immediately available, can I ask that the appointment be rescheduled?
In many cases, yes. However, if the patient would suffer because of the delay, you will want to have an alternative strategy available. The laws require "timeliness." Though there is no specific definition of "timeliness," the nature of the consultation and the urgency for treatment are factors that must be taken into consideration. A delay should not take place if the delay would reasonably deny the patient access to quality care.

For emergent needs, when it is not possible to have an interpreter assist in person, there are resources available, such as Language Line Services, which have interpreters available on a 24-hour basis.

Can we ask the patient or their representative to bring in a family member?
Family members or friends should not be used unless the patient so chooses, and only after you advise the patient of your obligation to provide an interpreter at no cost to the patient. While patients may be comfortable with family members, it is important to remember that the family member may not have the appropriate skills necessary to convey complicated health care information. There may also be situations in which the family member could have a conflict of interest.

Are we obligated to use an interpreter selected by the patient?
No. You are not required to utilize an interpreter designated by the patient. You can require the patient to use a qualified interpreter selected by you.

Who pays for the interpreter?
The provider or practice cannot charge the patient for interpreter services. Patients must be fully informed of the availability of a qualified interpreter at no cost to the

patient. Some providers who care for DHHS patients do qualify for reimbursement. However, coverage varies and you should not rely on reimbursement without first contacting the DHHS Medical Assistance Administration.

How do I identify a qualified interpreter?
Each state has established procedures for identifying qualified interpreters and translators, in both foreign languages and American Sign Language. Through a certification process, interpreters and translators are tested to demonstrate proficiency in and ability to communicate in both English and the other language. Good sources of referrals may be found in hospitals and at local public health offices. Develop a contact list of services in your area.

Where can I learn more about LEP?
We have put together a list of Web sites to help you identify resources and develop policies for working with LEP patients.

Resources:
The Department of Health and Human Services (HHS) provides policy guidance for the LEP requirement of Title VI at http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html.

NCIHC: National Standards of Practice for Interpreters In Health Care

Patient forms available in various languages

Links to Medical Translator and Interpretation Services

https://www.lep.gov/interp_translation/trans_interpret.html

A printable flashcard that can help providers identify which language a patient speaks www.lep.gov/ISpeakCards2004.pdf

Language Line Services www.languageline.com

National Council on Interpreting in Health Care http://www.ncihc.org/

Patient Complaint Management

Patient complaints may arise under a variety of circumstances in any clinical setting. Knowing how to appropriately manage these interactions is important and will be the focus of this section. Equally important is knowing how to investigate complaints and uncover any larger issues that may lurk in the practice to correct them before patient harm or practice harm occurs. For more detailed information on investigation methods refer to Chapter 9, Quality Improvement/Patient Safety.

When handling patient complaints, your staff's best course of action is a coherent, concise response that preserves patient confidence and satisfaction, as follows:

1. **Listen**
   Stop what you are doing and give your undivided attention to the patient. If you are on the phone, make appropriate responses so the patient knows you are listening. Do not argue with the patient or interrupt with explanations. Listen without attributing fault.
2. **Empathize**
   Put yourself in the patient's place. Offer a statement of empathy (e.g., "I'm sorry that ...," or "I understand that ..."). Do so without agreeing to guilt on your part or on behalf of the practice. Extend understanding without agreement.
3. **Inquire**
   Gain as much information as you can about the problem. This will help you decide the best way to handle the complaint. Be sure the patient knows you take his or her concern seriously.
4. **Act**
   Suggest solutions you can perform. Get the patient's approval on the recommended action (e.g. "I will contact ... and ask her to get back to you"). If no immediate action is apparent, assure the patient that an appropriate manager will be informed and that he or she can expect a response.
5. **Conclude**
   Thank the patient for taking the time to notify you of the complaint. Stress that patient satisfaction is a critical component of quality patient care in your practice.
6. **Document**
   Give any patient and/or family member with a complaint an opportunity to document it. Create a simple form that contains the patient's name and date of the complaint, the patient's statement of the problem, the staff member's statement or response, a description of the action taken, and the staff member's signature with a date.

The form both assures patients that their complaints are taken seriously and provides documentation that can help forestall potential problems and educate staff on how to prevent future similar complaints.

Angry Patients

Also see Chapter 12-Safety Management

The Four-Step Process for Managing Emotional Patients:

Patient Complaint - *"I'm so angry! This is the worst medical office in town and I can't get the care that I need, because nobody in this place knows what they are doing! You people can't get a simple prescription called in correctly the first time!"*

Staff response: Agree with them. When we agree with someone, they instantly lose an adversary and can't argue with us. Now, when I say agree with them, you are agreeing that they are frustrated and need some assistance. *Your response would be along the lines of "You're right! You sound very angry."*

Empathize with them. When we show empathy, we are conveying that we are truly trying to put ourselves in their position. This is a form of engagement and builds positive relationships. An example of an empathetic response after you agree that they are angry in the situation above would be *"We don't want any of our patients to feel this way. I'd like to work with you to fix this."*

Offer two options. When patients are presented with a choice on how to resolve an issue, they feel in control of the situation. Present only two or three options that you feel will resolve the issue. Usually, any more than two or three will become a bit confusing or overwhelming. In the above example, a suggestion would be *"When we fill your prescription, would you like us to call you or email you that it has been completed? When we do that, we'll also be confirming the name and location of the pharmacy, the name of the prescription, and how to take it."* Now, this may seem cumbersome, but for this particular example, you will most likely only have to do this once or twice. Trust me. As a previous practice manager, this is a real-life example. I only had to do this twice with the same patient until he felt a higher level of confidence in our process.

Follow up. By following up, it shows that we care about the situation and the patient's level of satisfaction with us. We need to show them that we are genuinely concerned about doing right by them. By following up, we also have the opportunity to discover if there actually is a glitch in our system or process. We then have a second chance to fix it. In our example we would say something like, *"Mr. Jones, its Kristina from Dr. Smith's office. I wanted to be sure that your prescription was filled the way that you hoped it would be. Were you able to get it from the pharmacy you specified? And it was the correct medication and dosage? Great! I'm glad that we were able to get that done right for you."* There are a few key phrases in there that will enable the patient to confirm that you did everything to their specifications and that you are happy that you did.

Thank them. At this point, it is highly recommended that you thank the patient for letting you know there was an issue and allowing you to fix it. By doing this, you are telling them that you want the relationship to continue. Remember, patients aren't really buying your medical care. They are buying the relationship they feel they can get with your physicians and staff.

It is highly recommended that you develop some sort of system within your office

to flag patients that have had issues that needed attention. This will connect the dots in the office and ensure the physician is aware too. When everyone concerned is working together, the patient will be much more likely to feel pleased with the outcome.

This process demonstrates a patient centered practice and mindset. Patients can feel instantly when their needs are the focus of a practice. Some of us get so wrapped up in our office functions and policies that we forget that the patients are there for us to take care of them as individuals with emotional and physical needs.

In the case of the emotional patient, they are truly looking for empathy above all else. When we are genuinely engaged with our patients, they will trust that we are working in their best interest.

Guest Author: Kristina Evey and Centric Strategies visit www.CentricStrategies.com

Resource: Sample Policy: Patient Concerns

H.E.A.R.T. Model: Responding to CONCERNS and COMPLAINTS

H.E.A.R.T. Model — **Responding or being reactive to issues**

Hear

Do:

- Take time to hear what they are *really* saying
- Resist defensive urges
- Write down key information

Don't:

- Interrupt or "jump in" right away

Empathize

Do:

- Show you care, e.g., "I understand how it could be frustrating to get the wrong directions."
- Verbally affirm partnership, e.g., "I am so glad that you called this to my attention. It is clear that you are upset by the events that you have described."
- Monitor your non-verbal messages

Don't:

- Avoid the person
- Make excuses
- Rationalize
- Judge

Apologize

Do:

- Offer a *sincere* apology, e.g., "I'm very sorry that you feel the information was confusing," or "I am sorry that you feel your pain has not been managed. Let's talk about what we can do about that."

Don't:

- Assign blame to others
- Minimize concerns

Resolve or Refer

Do:

- Ask questions (not before this point!)
- Ask what they think would correct the problem
- Discuss alternatives and what you can do
- Establish a plan for resolution with an identified timeline
- Take action; solve minor problems quickly
- Refer issues to others as appropriate—office manager, physician, patient relations, risk management

Don't:

- Give people the "run around"
- Demonstrate apathy
- Over promise

Thank Them

Do:

- Thank them for the opportunity to correct the problem and prevent it from happening again
- End with an invitation for continued partnership
- Follow up—personally and in writing
- Document as appropriate

Terminating the Physician/Patient Relationship

When terminating the physician/patient relationship a couple of considerations come into play in order to reduce the risk of the physician being charged with patient abandonment or other ethical issues:

Non-Compliant Patients:
Make reasonable attempts to help the patient conform their behavior to what is required. This would involve telling the patient what the expectations are and, when indicated, offering some level of reasonable assistance to meet those expectations. (For example, a counseling referral might be appropriate in some situations.) Ideally, a new patient to a clinic would be provided with a written document outlining their responsibilities and the potential consequences of non-compliance. Some providers use “contracts” that include such behavioral expectations, however, a signed contract is not a necessary prerequisite to termination.

If the problematic behavior continues, and it's determined that the behavior has created too much of a disruption on operations or that the behavior renders the treatment plan ineffective, the relationship can be severed, with appropriate notice, unless there is a 3rd party payor restriction on termination. For example, a provider contract with an HMO might require that the provider discuss the problem with the health plan prior to termination.
Also see the section in this Chapter on non-compliant patient behavior.

Pregnant Patients:
You cannot discharge a patient in an unstable clinical condition without making arrangements for another physician to take over the care seamlessly. This especially includes pregnant patients. Our recommendation is once they are in the third trimester (24 weeks gestation) or are high-risk; the physician needs to find another OB who agrees to take over the patient’s care. The physician should not terminate this type of patient without having arranged for continued care elsewhere, as potential abandonment charges may result.

Narcotics Seekers:
A common reason to fire a patient is that they are scamming for narcotics. It is recommended that a physician continue to care for these patients for 30 days (standard time frame), but will no longer provide any more narcotics immediately. We draw a distinction between someone scamming for narcotics versus a chronic pain patient with a legitimate medical need. In some rare cases, it may be appropriate to extend the 30-day cutoff period for a chronic pain patient since it can be so difficult for them to find someone else to manage their pain.

Abusive/Threatening Patient - Immediate Termination:
The only scenario in which a patient should be terminated immediately with no notice is if they are threatening either the physician or office staff. In this circumstance, send the patient a letter ending the relationship immediately, but still provide notice on where they can find another source of care, such as the county medical society's physician referral line. Explicit detail in the letter is warranted including the acts of violence or threatening behavior or language that has resulted in the immediate termination. By doing so, the physician may successfully defend ethics complaints for abandonment. Be sure that the chart documents violent or threatening behavior.

Non-Paying Patient:
Finally, the most common reason to terminate a patient is that they don't pay their bill. We want to make sure that the business office is not making a unilateral decision to terminate a patient without involving the physician. There are many ethics and discrimination (inability to pay) complaints in which the physician was surprised that the patient was fired without his or her knowledge or approval. For large medical groups, designing a process in which all patient terminations first have to be reviewed and approved by the business office, the attending physician, the risk manager, and a medical director is best. This ensures that a clinically-unstable patient is not inadvertently fired by a billing clerk. For small practices, the physician should be consulted and provide approval before any termination occurs.

Elements to be included in the termination letter:

- **Emergency care provision:** Some state medical licensing boards may have statutory or regulatory mandates, or the Disciplinary Committee of the state medical society may have specific minimum time frames in terms of continuing to provide care-see below on Michigan requirements.* The most common requirements are either 15 or 30 days. If there are no specific requirements, we recommend 30 days notice for emergency care only be included in termination letters.
- **Follow-up care:** Specify what care is required to treat the patient's condition, state the frequency and necessity of follow-up and be sure to include the consequences of not getting the follow-up, in clear, user-friendly language. (Including such information and warnings minimizes the risk of allegations of failure to provide continuity of care/failure to warn/failure to obtain informed refusal.) Also, keep in mind the health literacy level of the patient and adapt the language accordingly.
- **Records transfer:** Offer to transfer medical records to a newly designated provider upon receiving a signed patient authorization to do so.
- **Reason for termination:** In the letter, give the patient a brief explanation of why you are terminating the relationship. Include details of the patient's

problem behavior. This detail is important because it can help demonstrate that the action was taken for a legally permissible reason and was not based on an unlawful motive, such as discrimination involving individuals with disabilities.

- **Documentation:** Document notification and the reasons for termination in the patient's medical record & include a copy of the letter.
- **New provider:** Help the patient find another provider. Generally, this can entail giving the patient the address/phone number of, for example, other clinics in the community or just the local medical society/physician referral service.

Mailing Process:
There are two ways to send the termination letter: U.S. Postal Service or Certified mail. It is advised that if you have a patient that you want to be certain receives delivery of the termination letter then send it by both methods. If the certified letter is refused but the regular Postal mail is not returned. You may assume that the letter was indeed delivered to the addressee.

It is not necessary to send termination letters by certified mail for all cases. In many cases sending them by Postal service will be sufficient. However, if for any reason you are concerned the patient may allege they never received the letter –and state how could the 30 days have expired? You will want to use the method described above to ensure you are free of this patient.

Simple Sample Language:
"Due to circumstances, including [insert specifics here], I have become uncomfortable continuing my physician/patient relationship with you, and therefore, must now terminate that relationship. I will continue to provide you with emergency medical care in the field/specialty of [insert] for the next thirty (30) days. However, please make immediate arrangements to receive your ongoing medical care from another provider. [Consider inserting the medical society contact information or recommend the patient contact their healthcare insurance company] I will facilitate the transfer of your care in any way in which I reasonably can and wish you the best in the future. Enclosed is a records release that will allow us to transfer your records to a new provider."

Resource: Sample Patient Termination Letter

***Reasonable Notice Requirement for Michigan:** According to Michigan case law, a physician needs to give "reasonable notice" to terminate the physician-patient relationship so that the patient can have time to find new medical care, and the physician is safe from patient abandonment claims. Tierney v. University of Michigan

Regents, 669 N.W.2d 575 (2003) ("[A] physician has a definite right to withdraw from the case provided he gives the patient reasonable notice so as to enable him to secure other medical attendance.") This has been established by case law since 1935. Fortner v. Koch, 261 N.W. 762 (1935).

Further, according to MCL 333.20201(f) - commonly referred to as the patient bill of rights law - "A patient or resident is entitled to refuse treatment to the extent provided by law and to be informed of the consequences of that refusal. If a refusal of treatment prevents a health facility or agency or its staff from providing appropriate care according to ethical and professional standards, the relationship with the patient or resident may be terminated upon ***reasonable*** notice."

Reasonable notice, according to the research, has been generally interpreted as at least 30 days. A specific Michigan rule was not located on this. Research also indicates that this 30 day notice period is typical across the country and is the period provided in every sample termination letter located via research (regardless of the state). *Provided by Megan M. Hard, JD SHRR*

Office Risk Management Self-Assessment

The purpose of the Physician Office Practice self-assessment is to assist the practice manager in identifying potential risks within the physician office setting. It covers the usual systems found within the office practice including reception, medical assisting and back office functions, medical records and release of information, and other common policies and procedures. A practice manager can use this tool to conduct an on-site survey of their practice. It can be used as a pre-assessment tool for practices to perform a self-assessment for potential risk areas. The assessment covers the common office systems and practices that are known factors in malpractice claims. Finally, the practice manager can use this as a baseline tool to develop improvement goals.

Resource: Sample Office Practice Self-Assessment survey, Refer to your office survey results conducted through the Physician Practice Patient Safety Assessment offered by MPIE between 2007-2010.

Closing Your Practice-Retirement-Relocation-Sale

A variety of circumstances may lead a physician to end his/her current practice arrangement. To ensure continuity of patient care, to avoid any allegation of abandonment, and to fulfill contractual and regulatory obligations, the physician should provide notice in a timely manner. This responsibility often applies to a physician departing a group practice. If feasible, begin planning your departure years in advance.

Address the Following in your Planning:

Staff

- Keep staff informed. Notify employees three (3) months in advance of the anticipated closing date. Outline a plan regarding a severance policy and benefits. Consider providing incentives to encourage valued staff members to continue their employment and ease the transition to closing the practice. Options to consider offering are an exit bonus, an increase in base salary, or continued employment if you sell the practice.
- Negotiate to enable your staff to retain their positions if the practice is acquired by another physician. Familiar staff facilitates the transition of patients to the new provider-owner.
- Arrange for staff interviews with the acquiring physician. If needed, provide an outplacement service to provide resources that assist staff in obtaining other employment.
- Ensure that you fulfill all legal requirements related to any employment retirement plan.
- Determine what obligations you have in relation to your employees' health insurance coverage and your obligations to pay unused employee benefits such as vacation and sick time.

Patients

- Notify active patients a minimum of three (3) months prior to closing, enabling them to locate another physician and adjust to the transition. Notify by letter (sent first class mail) and enclose a records release authorization form for patients who are currently undergoing treatment or, who were seen by the practice within the last 2 years.
- Consider calling each patient that has a chronic or complicated medical condition (high risk). Follow up with a letter advising them that their condition requires ongoing medical attention and that a physician must be selected to provide for their continuing care. (A certified letter, return receipt requested may be sent in lieu of a telephone call). Determine whether it is necessary to actively transfer the care of compromised patients.
- When establishing an end-date, surgeons must consider the post-operative follow-up period and refrain from scheduling surgical cases beyond that time frame.

Insurance

- Contact your liability insurance carrier. If you have a "claims-made" policy, tail insurance will protect you from a claim filed after you stop practicing.
- Inform every insurance company providing any form of coverage for the practice, (e.g., facility, vehicles, and employees).

Newspaper Advertisement

- Place a notice in at least two (2) area papers serving your patient population. If you are a specialty physician and see patients throughout your state, it is in your best interest to utilize periodicals that circulate state-wide. The information contained in the notice is not regulated by any entity. The size of the ad must be large enough to ensure that it is easily seen. Publish the ad several times within a month. You should include the following information:
  - Date you are closing the office
  - Date you will stop scheduling patient appointments
  - Information related to transferring a copy of patients' medical records to another physician
  - An explanation of how patients can obtain copies of their medical records.

Key Entities To Notify

- State Licensing Board
- State and Local Medical Societies
- Drug Enforcement Administration (DEA) (Controlled drugs should be discarded in accordance with DEA procedures and your DEA license returned)
- Hospitals
- Associates
- Medicare
- Medicaid
- Third-party payers, MCOs, Workers Comp
- Professional Associations, AMA, AOA.

Medical Records

- A valid, signed authorization is necessary to provide a new physician a copy of a patient's medical record. The physician-patient relationship is normally an individual relationship. Obtain each patient's consent to allow colleagues in a group practice to assume care and access your patients' medical records. Do not release the original medical record. Forward a copy of a complete file to the new physician. You may not withhold the records of a patient whose account is in arrears. Be sure to retain medical records according to your state's requirements.

Storage of Medical Records

- Safe storage requires that the confidentiality of the records be protected. Storage options include: archiving records, using a storage firm, arranging for a custodial physician, scanning into a read-only CD or copied to microfilm.

- Arranging for Physician Custodians of Medical Records
  A written agreement is encouraged, and it should address the following:
  - Length of time to maintain the records
  - Indemnification provisions
  - Access by a patient or the physician to the medical records.
- Storage Facility: Any relationship established with a firm that handles the storage of sensitive information should include a formal written contract outlining the mutual obligations of the storage firm and the physician. There should also be in place a HIPAA business associate agreement with the storage firm. Before contracting with any such facility, some due diligence should be performed to verify the contractor's ability to maintain the confidentiality of medical records and its ability to limit access to appropriate persons.

Destruction of Medical Records

- See Chapter 4 of this Manual on Retention and Destruction.
- Some older inactive records may be purged. Confidential destruction (shredding) is an option. Contact either your local hospital which may have the capacity to safely dispose of medical records or, an attorney, to locate a secure record destruction service. HIPAA requires that a business associate agreement be entered into when a destruction service is used.

Additional Considerations

- Review your contracts related to notification requirements. It is always advisable to contact your attorney to ensure compliance with state laws and to review written contracts.
- Take into consideration the amount of time patients need to establish a relationship with another physician based on the location and availability of other similar practitioners in your geographic area
- Remember to destroy prescription pads and letterhead after your last appointment.

Resources:
Sample Closing Your Practice Letter
Retirement or Sale of Practice Checklist
American Academy of Family Physicians - Closing Your Practice Checklist
Michigan State Medical Society – 517-336-5714

Consultations

When referring patients to specialists it is a best practice to prepare a request for a consultation letter outlining the history of the patient's condition and specifying what you would like the consultant to evaluate. Appropriate medical records may be

enclosed with the letter to provide additional depth on the condition for the consultant physician. Often what occurs is that the consulting physician does not receive enough information on the patient or the patient provides inaccurate direction as to the reason they were referred, and the consultation visit may miss the mark on the desired input the referring physician was seeking.

Physicians that are consultants must always have a system in place to ensure the feedback loop is closed back to the primary care physician or referring provider. This is best achieved by writing a letter back to the referring provider outlining the findings and the next steps for treatment. It would be a best practice to copy the patient on this letter as well – this ensures that the patient is aware of the findings and treatment recommended and embraces a patient centered practice model.

Also see Chapter 1 of this Manual on Primary Care and Specialist Communication

Practice Coverage

It is recommended that when selecting coverage for your practice that you choose another physician that practices in the same specialty that you do.

Business Records Retention Terms

This sample records retention policy and procedures is based on the same form published by the Medical Group Management Association. Though we believe these dates to be sound, you may wish to check with your accounting or tax professional or with your business attorney if you have questions regarding the retention of financial or business documents.

Policy:
It is the policy of the Practice that personnel, financial, and medical records of the Practice are maintained in a safe and secure environment to ensure compliance with certain state and federal regulations according to the schedule set forth by this policy.

Procedures:

1. At the culmination of each year, the following records (see below) are organized and placed in storage filing boxes and taken to the central storage facility of the Practice or scanned for electronic storage on CD-ROMs and taken to storage.
2. In the case of electronic storage of documents, two copies of all CD-ROMs are made, and the original document is destroyed according to the destruction methodology described in the policy.
3. All file boxes or CD-ROMs are clearly marked with the document name and date in a visible location on the exterior of the storage file box or storage case. The Administrator or designee appoints an appropriate person to organize and deliver the boxes or cases to the appropriate location.

4. A document destruction company engaged by the Administrator or designee destroys all documents falling outside the retention time limit and/or documents that have been electronically imaged and stored.
5. The Administrator or designee documents the destruction process and the records submitted for destruction.
6. Records documentation are maintained with the corporate documents of the Practice.

Personal Records	
Recruitment ads, job postings	*1 year*
Interview evaluations	*1 year*
Hiring forms	*2 years*
Application forms	*2 years*
Promotion/demotion records	*1 years*
Transfer records	*1 years*
Discharge	*1 years*
Pay rates	*3 years*
Personnel tests	*1 years*
Background review	*1 years*
Physical exams	*1 years*
Drug screening	*1 years*
Bonuses	*1 years*
Employee benefits plans	*1 years*
Performance reviews	*1 years*
Earnings records	*3 years*
Time records	*2 years*
Deductions/additions to pay (individual)	*3 years*
Master payroll record	*3 years*
Employee information	*3 years*
Certificates	*3 years*
Retroactive wages	*3 years*
FICA (Social Security) records	*4 years*
Employment tax records (IRS, W-2, W-4)	*4 years*
OSHA records (illness and injury)	*4 years*
Form I-9 Employment Eligibility Verification	*2 years*
Retirement plan information	*6 years*

First aid record of job injuries causing loss of work time	*5 years*
Individual employee or union contracts	*3 years*
Records of employed minors	*Indefinite*
Personal Records	
All records of executive, administrative and professional employees	*Indefinite*
Withholding on sick leave	*Indefinite*
Medical benefit plans	*Indefinite*
Deferred compensation plans	*Indefinite*
Staff and benefit records summary *1. Greater of Title VII (Federal discrimination laws), Fair Labor Standards Act, Age Discrimination in Employment Act of 1967, Internal Revenue Service or State Employment Administration.* *2. Include in employees' individual personnel files.* *3. Both individual and master files should be maintained.*	*Indefinite*
Contracts	
Managed care	*6 years after expiration date*
Grants	*3 years after final payment*
All legal contracts	*State statute of limitations*
Insurance Company	
EOB (Explanation of benefits)	*5 years*
Payment documentation (electronic back-up or ATB report)	*5 years*
Workers' Compensation	
Documentation of on the job injury	*Indefinite*
Hazardous substance exposure report	*Indefinite*
Corporate Records	
Articles of incorporation	*As long as corporation is active*
Corporate minutes	*As long as corporation is active*
Board minutes	*Indefinite*
Miscellaneous correspondence and administrative papers	*1 year*
Partnership agreements	*6 years*
Physician corporate employment agreements	*6 years*
Stockholder agreements	*6 years*
Deferred compensation agreements	*6 years*

Management Records	
Charge tickets/Superbills	*1 year*
ATB reports	*3 years*
Payer reports	*3 years*
Productivity reports	*3 years*
Monthly summaries	*3 years*
Insurance records	*3 years*
Claims reports (including electronic filing)	*3 years*
Third party correspondence	*3 years*
Business correspondence	*1 year*
Insurance policies	*3 years*
Malpractice policies	*Indefinite*
Budgets and variance reports	*3 years*
Revenue analysis reports	*3 years*
Tax Records	
Annual income tax returns	*6 years*
Accountant reports	*6 years*
Balance sheets	*6 years*
Income statements	*6 years*
Compensation distribution records	*6 years*
Incentive/bonus distribution	*6 years*
Property (assets) records	*6 years*
Investment records	*6 years*
Depreciation schedules	*6 years*
Change in tax base	*6 years*
Building improvements	*6 years*
Any documents supporting tax deductions	*6 years*
Banking Records	
Duplicate deposit slips	*1 year*
Cancelled checks	*7 years*
Monthly bank statements	*1 year*
Cancelled checks for major items including: taxes, major asset purchases, real estate improvements, special contracts, etc., should be filed with the corresponding papers and retained indefinitely.	

Medical Records	
Adult records- retain records for 10 years from the last date of treatment/visit.	
Pediatric records- retain these records until the minor reaches 25 years of age.	
Deceased patient's records- retain records for 10 years from the date of death.	
Obstetric patients- who encountered difficulties- keep records for 21 years from the birth of the child (unless neurologically impaired-see below)	
Neurologically impaired adult or infant- retain indefinitely	
Legal Documents	
Deeds	*Indefinite*
Mortgages	*Indefinite*
Bill of Sale	*Indefinite*
Non-government contracts	*6 years after no longer active*
Government contracts	*3 years after last payment*
Miscellanous	
Correspondence and administrative papers	*1 year*

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Incident Reporting, Risk Assessment & Satisfaction Surveys

How does a practice go about improving performance and the quality of care provided to patients? Most often it is through the collection of data, specifically incidents reports, risk assessment results, and patient satisfaction surveys. Incident reports are documentation of an event or occurrence that is out of the norm. Often incident reports are thought of being associated with an error – this is true. Often incident reports are created for errors but they have just as much if not more value when they are created for other system-related abnormalities. It is through the collection of these reports and the findings of risk assessments and patient satisfaction surveys that a practice will be able to identify problem areas and begin to focus their improvement efforts.

Resources: Sample Incident Reporting Policy and Procedure for the Physician Practice
Ambulatory Patient Safety Tool Kit –this document is an excellent resource for explanations and sample forms to be used in a creating a safety improvement program in the ambulatory care setting.
Mini Office Risk Assessment: Sample Office Practice Self-Assessment
Patient Satisfaction Surveys: Medical Practice Survey Template

Do's & Don'ts of Incident Reporting

Just Culture

An organization's "culture" can be found in the pattern of shared basic assumptions about the organization's values (what is important), beliefs (how things work), and behaviors (the way we do things) that have been taught to the workforce in both explicit and implicit ways. Thus, the culture encompasses both the observable customs (behavioral norms, stories, and rites) that occur in an organization as well as the unobservable (assumptions, values, beliefs, and ideas) shared by groups.

The most common means of measuring organizational culture is to survey an adequate sampling of staff. Two examples of validated survey tools can be found on the Web sites of the Agency for Healthcare Research and Quality (AHRQ) (http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html) and the Health Research and Education Trust (HRET) (http://www.hret.org/quality/projects/walkrounds-saq.shtml). These tools, which were both launched in 2004, can be downloaded free of charge. In March 2006, AHRQ also began gathering eligible survey data into a central repository, which may become the first nationally available

comparative database on organizational culture. For more information, see the article below.

Provider Performance Improvement/Peer Review

Concerns or complaints about a provider's performance can come from many sources including, but not limited to: patient calls, letters or satisfaction surveys, communications from health plans, inquiries from state or federal regulatory agencies, civil or criminal investigations or lawsuits, information reported by peers or coworkers to practice management, legal counsel, compliance office or chief medical officer, calls to the Group hotline, or issues discovered during the credentialing or re-credentialing process or issues identified during other organizational quality improvement initiatives. It is important for a medical group to oversee the quality of its providers by having a single centralized process to collect, investigate and appropriately address, in a timely manner, any concerns involving the quality of service, professional competence or utilization management of a credentialed provider. For the review process to occur a formal QI policy must be written and followed. An example policy is offered to assist practices in developing their own process for review.

Resource: Sample QI Policy for Large Physician Practices

Here we provide assistance in developing peer review criteria on provider performance. Peer review within a group is an important component of a medical practice. It can help colleagues solve problems in the early stages before they become serious enough to be career-threatening. Much peer review is done on an informal basis through consultation and referrals. Although these informal mechanisms can be very effective, as a group grows larger in size, a more formal method of physician evaluation may be helpful.

These forms may not be feasible for all practices, but they should be helpful in addressing the issue. It is possible that this information could potentially be discoverable in the event of a malpractice claim. However, we believe the possibility of an occasional discovery request should not impede the implementation of an effective review program. You may also want to engage legal counsel in the review process as a potential protection method.

Peer-review under any circumstance is very subjective. We hope the Annual Review Discussion Topic Form will be helpful in enhancing your informal or formal review process.

Resources: Annual Review Discussion Topics, Physician Evaluation Form, Annual Physician Review Process Map

Office Performance Improvement

More in-depth information on performance improvement in Ambulatory care from an operations and patient safety perspective is available in a separate MPIE manual-titled *"Quality Improvement, Patient Safety & Efficiency in the Outpatient Practice".* This section acts as an overview of topics of interest related to performance improvement.

An improvement story: One example of a patient safety performance improvement tool that was developed by an office was in response to patient non-compliance with treatment plans. It was not that patients were purposefully non-compliant but rather were having difficulty following the rather complex directions. A communications failure problem was identified, and an opportunity was seen. The practice developed an office discharge form much like what is used when a patient is discharged from the hospital. This form contained all the important data of that day's visit and what needed to be completed next or followed up on. A copy of this Discharge form is available in the samples section of this manual. The practice was able to improve their compliance rates significantly with this small change. They measured compliance before and after the use of the form was put into place to ensure their change was indeed improving compliance and had the desired result they intended. They also looked for any potential unforeseen consequences of using the form so they could be addressed or modified. This improvement plan was so impressive and successful that it is shared here in this manual and every practice is encouraged to adopt the use of this form and the process of a formal discharge step in the course of a patient visit.

The following two resources provide a well-rounded overview of performance improvement methods and the basics of how to conduct performance improvement in relation to financial matters.

Title: *Lean Six Sigma for the Medical Practice*

Profit is a ratio of revenue to the expense. In order to be more profitable, traditional thinking says you need to reduce expenses and/or increase revenue, both increasingly difficult, if not impossible tasks, for many practices. So, if you can't do either, what options are left? Lean thinking says improve efficiency. What if you could do more with your current resources? What if you could see more patients or perform more procedures without adding to your fixed cost? And at the same time improve quality and reduce compliance risk? This is exactly what Lean Six Sigma (LSS) will do for your practice. During this program, the instructor will introduce you to the concepts and ideas behind LSS and show you how it can be applied specifically to the medical practice. When complete, you will know whether process improvement is the way for you to go and if so, how to obtain the resources and information

necessary to embark upon your own LSS projects.

Safety as a Component of Medical Practice Design

Definition of a system: A system is a set of interdependent parts with a common aim.

- The parts may be people, procedures, infrastructure, or other elements.
- The parts are interdependent because the functioning of one depends upon the functioning of the others.
- The emergent relationship between the activities of each element, make a system more than the sum of its parts.

All systems are perfectly designed to produce the results they produce.

- To improve outcomes, you must improve the system.

What does quality health care look like?

- Freedom from errors — A safe system
- Consistent best practice — A reliable system
- Great service — A great service system

For a system to produce these outcomes, these aims must be BUILT into the system itself.

Analyzing and improving your systems

1. Consider a given system (refill authorization process, referral communication process, lab results handling)
2. Write down each of the individuals involved in that process and note the number of interactions involved.
3. Write down where the process is subject to error and note why these particular spots are error-prone.
4. Write down a specific goal to achieve for the process (i.e., “all referrals followed up”).
5. List particular ideas that might help you accomplish this aim

The two most important system elements for the ambulatory practice are workflow and team work. Efficient teams and smooth workflow make for reliable systems.

Improving Practice Reliability

Proactive population management

Proactive population is about improving the care of individuals in our practice by proactively understanding and tracking our practice’s performance for various clinical populations. Understanding how we are doing against a whole population of

diabetics, for example, helps us to improve the care of INDIVIDUAL persons with diabetes. A practice REGISTRY is a document system, electronic or not, that lists all the patients with a particular condition. For example, a registry of patients with coronary artery disease might track whether the patients are on aspirin and beta-blockers, is their HTN controlled, and are their lipids at target.

Consider DECISION-SUPPORT TOOLS to improve efficiency and reduce error:

- Epocrates on a PDA to allow very rapid access of pharmaceutical information
- Sanford Guide on Antimicrobial Therapy to provide guidance on antibiotic choice
- Computerized order entry to reduce adverse drug events
- Reminder systems to improve the consistent application of best practices

Systems' Influence on the Delivery of Ambulatory Care

Medication

- Don't store look-alike pharmaceutical substances together
- Always double check that the medication you are about to apply is what you intend to use
- Print, don't handwrite
- Do not use abbreviations
- Advise patients of side effects that warrant a call to the physician

Patient Care

- Don't leave patients alone as they get off tables, etc.
- Advise patients to remain lying down if they must be left alone momentarily

Office Communication

- Develop a protocol for patient messages
- Use a telephone check sheet
- Organize messages according to urgency
- Meet with staff to see how to prevent error in the future, thereby creating team spirit
- Avoid lack of communication above all

Office Procedures

- Build redundancy into office processes to safeguard against memory slips and lapses
- The need for redundancy is proportional to the seriousness of consequences should something go wrong

Lab Results

- Make sure a physician familiar with the pathology reviews and signs off on lab results

- Always send a letter with test results to the patient
- Make a personal telephone call with critical lab results

Time Management

- Do not let time pressure force you to take shortcuts that have been shown to lead to medication errors
- Under time pressure, be aware of the fact that it is a normal response to try to catch up
- Be efficient with all due process
- Accept that an hour only has 60 minutes

Test Tracking and Patient Follow-Up Systems

The number one reason for litigation stemming from the physician practice setting is the delayed or missed diagnosis or treatment due to a missed test result. It is essential that all patient information be handled in an organized manner so that key pieces of information that may determine future treatment are provided to the physician in a timely manner. A tracking system should be in place for diagnostic tests and a patient follow up system for return visits and referrals outside the office.

Develop a Reminder "Tickler" File

To track patients, they are in need of return visits or follow up on tests the office may which to use a system such as the one described below:
Obtain a 3"x5" card file with monthly dividers.

When the doctor indicates that the patient needs to return for follow-up of a condition, you fill out a card with the patient's name, patient file number, telephone and address (it is more convenient to place it here than looking it up on the chart), the reason the patient needs to return and the month and year the follow-up is due. This system can also be used to follow up on patients referred for outside consultation.

Place this card in the file box in the month the patient needs to return.

There are two ways to complete the process: a Pre- and Post- Initial Contact:

Pre-Contact - If you wish to remind the patient prior to the due date, then pull all cards in the month before the patients are due to return. Call or send a reminder card/letter to them. It is important to keep the cards until the end of the month in which the patient was supposed to return. You need to recheck these at the end of the month and notify those patients who failed to keep their appointments.

Post-Contact - You may wish to eliminate the double-check system above and simply pull all the cards at the end of the month and check charts to verify if the patients did return for follow-up. Those patients who did not return for a follow-up

would then be notified.

Generally, follow-up attempts include one phone call; and if that is not successful, then a postcard or letter. These attempts should be documented in the chart. If the condition is serious, i.e., following a potential cancer patient, you may want to send a certified letter with return receipt requested. This receipt is then filed in the chart with a copy of the letter for documentation purposes.

Recall log

A patient recall log for all tests, procedures and consultations ordered by the physician may be used as well; the log allows the practice to notify patients of normal results. The log will alert the doctor if patients have not followed treatment or testing orders and the patient can be called to follow through. A log tracking system can be kept in a three-ring binder, including a no show log, lab/x-ray log, and a specimen log.

Patient Notification

New research shows that physicians failed to report clinically significant abnormal test results to patients — or to document that they had informed them — in one out of every 14 cases of abnormal results.

Investigators revealed that groups using simple processes to manage test results had lower failures rates. Groups that did not consistently use these processes had both higher failure rates and physicians who were dissatisfied with their group's processes for managing test results. The study also found that having an electronic medical record did not reduce failure-to-inform rates - and even increased them - if the practice did not have good processes in place for managing test results.

The study suggests that five simple, common-sense processes are useful for dealing with test results:

1. all test results are routed to the responsible physician;
2. the physician signs off on all results;
3. the practice informs patients of all results, normal and abnormal, at least in general terms;
4. the practice documents that the patient has been informed; and
5. patients are told to call after a certain time interval if they have not been notified.

In many cases, physicians and their staff told patients that **'no news is good news'** — meaning they should assume that their tests are normal unless they are contacted. This is a dangerous assumption and **should NEVER be your notification process.**

Source:

Physicians Frequently Fail to Inform Patients About Abnormal Test Results

When unsuccessful attempts have been made to notify a patient about abnormal or alarming diagnostic results, a certified return receipt letter should be strongly considered. The letter should be marked “Personal and Confidential” and should be tactfully drafted, expressing appropriate concerns for patient welfare and when indicated, warnings regarding the consequences. If circumstances warrant, the letter should also indicate the withdrawal of the doctor from the patient’s care if the patient’s noncompliance continues. Notations of all actions and copies of all letters sent to the patient should become a permanent part of the patient’s medical records.

Rationale for Follow-Up Systems

You may wonder where the patient’s responsibility lies in returning for follow-up. In general, court decisions have held that it is the healthcare professional’s responsibility to make an attempt to contact and encourage the patient to return for needed follow-up. It is felt that the healthcare professional appreciates the “seriousness” of the medical problem more than the patient.

Physician Review

EMR: Many computer programs have excellent recall and follow-up capabilities. However EMR tracking systems are only as good as the human responsible for checking them. An emerging area of risk and liability is the reliance on the EMR to “notify” the physician of an abnormal test result or confusion as to what constitutes reviewed vs. acted on–which may result in the physician’s failure to timely review all test results waiting in their queue. Having a RN or Advanced Practice Professional responsible for the first review of all results separating normal from abnormal reports allows the physician to review and direct follow up on those requiring attention is a common practice. During this time of mass transition from paper to EMR it is expected that the unexpected will occur and it has – in the already established area of highest risk for error and litigation- test tracking.

Paper Records: Laboratory, x-ray, and pathology reports should be initialed and dated by the physician as they are reviewed. Diagnostic results or consultation letters from other physicians should not be filed in the patient’s medical records until they have been reviewed, initialed and dated by the physician.

Critical Values

A documentation and reporting system for handling results of tests called in from a hospital or outside laboratory that need the immediate attention of the physician should be instituted. The system should demonstrate that the doctor was notified immediately and what subsequent action took place. Documentation must be kept as a permanent part of the medical record.

THERE IS VALUE in the attempted follow-up and documentation of this process.

A "Failure to Diagnose" claim can be one of the most serious types of malpractice cases today. Many of these cases result from a detrimental delay in following a condition. Oftentimes the doctor is totally unaware that the patient failed to return as requested, so months elapse and the condition worsens.

Patients sometimes are charged with "contributory negligence" when the jury feels the patient contributed to some degree in the damage. Awards may then be reduced by the amount or percentage the jury felt the patient was responsible.

If the doctor can show from chart documentation that attempts were made to contact the patient to return for follow-up, then this documentation provides a better defense. It can help prove contributory negligence on the patient's part.

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#10: Advanced Practice Professionals

The changing face of healthcare, coupled with growing consumer demand for primary care, sets the stage for the emergence of allied health professionals, often referred to as “physician extenders.” These allied healthcare professionals bridge gaps between medical practice and traditional nursing, and often perform many routine medical procedures, thus giving physicians more time for activities requiring a higher level of training and experience. It is essential for physicians to understand the roles and limitations for these “extenders,” as well as the attendant liability issues. These healthcare extenders fall into two main groups: advanced practice nurses and physician assistants.

Advanced Practice Nursing

Advanced practice nurses (APNs) are registered nurses who have completed advanced education and clinical practice requirements. APNs work in a collaborative relationship with physicians. APNs include registered nurse practitioners in several specialty areas (e.g., neonatal, midwifery, ob/gyn, geriatrics) and certified clinical nurse specialists, professional nurses who are certified as a specialist in a particular

field of clinical nursing, e.g., nurse anesthetist or nurse midwife.

Registered Nurse Practitioner
Registered Nurse Practitioners (RNPs) are licensed and regulated by the State Boards of Nursing to function in extended nursing practice. The role of the RNP was originally developed primarily as a means of the increasing availability of healthcare. Nurse practitioners lighten the load of overburdened physicians in busy practices by performing functions such as taking patient histories, performing physical assessments, and ordering various tests.

Certified Nurse Midwife
Nurse-midwifery practice is the independent management of women's healthcare, focusing particularly on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecological needs of women. The Certified Nurse-Midwife (CNM) practices within a healthcare system that provides for consultation, collaborative management, or referral as indicated by the health status of the patient. Comparable to the scope of practice of the Nurse Practitioner, the CNM does not require a supervising physician but should have a network of physicians available for appropriate collaboration or referral.

CRNA – Certified Registered Nurse Anesthetist
Generally employed in a hospital or outpatient surgical facility rather than an office setting, CRNAs practice according to their expertise, state statutes or regulations, and institutional policy. CRNAs are extended role nurses regulated by the State Boards of Nursing and practice according to the guidelines of the American Association of Nurse Anesthetists.

CRNAs administer anesthesia and anesthesia-related care in four general categories:

1. Pre-anesthetic preparation and evaluation.
2. Anesthesia induction, maintenance, and emergence.
3. Post-anesthesia care.
4. Peri-anesthetic and clinical support functions.

Physician Assistants

An extension of the physician, the Physician Assistant (PA) is licensed by the various state boards of Medical Examiners to "perform healthcare tasks according to a dependent relationship with a physician." To be licensed, each PA must have a designated "supervis¬ing physician" who is responsible for all aspects of the performance of the PA, whether or not the supervising physician pays the physician assistant's salary. Under the terms of supervision, the PA may obtain patient

histories, perform physical examinations, and order and perform diagnostic and therapeutic procedures. The PA may formulate a diagnostic impression, develop and implement a treatment plan, and monitor effective¬ness of therapeutic interventions. The PA may also offer patient educational counseling and make appropriate referrals to physicians and other healthcare professionals.

A physician assistant may prescribe many medications, including scheduled IV or V controlled substances and specially trained PAs may assist with surgery. An appropriate degree of supervision of the PAs activities ranges from direct on-site overview to a minimum weekly review by the physician of patient records in which the PA has made entries. Direction and supervision generally do not require the personal presence of the physician at the place where the healthcare tasks are performed.

Liability Concerns

Most malpractice claims attributed to mid-level providers can often be traced to clinical and administrative factors that are easily identified and remedied:

- Assumption of too much responsibility
- Inadequate physician supervision
- Absence of written protocols
- Deviation from written protocols
- Failure and delay in seeking referral or physician collaboration

Consequently, there are precautions and assurances that the employing physician should initiate. Determine that your mid-level is not providing services beyond their capabilities or those not permitted by law. Monitor the practitioner's work closely at first, until you achieve a comfort level with their abilities, and at regular intervals after that to assure continued quality performance. Monitoring enables detection of misdiagnoses, delays in diagnoses, improper orders, or any other issues requiring attention. Mid-level providers are the agents of their employers - their malpractice reflects directly upon the supervising physician.

Risk Management Guidelines

- Check credentials carefully – verify education and employment
- Verify that all licensing and certification requirements are current
- Obtain authorization to conduct credentialing verification
- Utilize a skills checklist
- Obtain hospital privileges for extender, when needed
- Notify managed care plans, when required
- Develop a written job description(s)

- Develop written guidelines and protocols
- Ensure that all staff members understand the extender's role and limitations
- Obtain state licensing board guideline requirements
- Clarify the type and extent of physician supervision required
- Require that staff and extenders wear a name badge delineating their title
- Ensure there is appropriate professional liability insurance covering all staff
- Periodically test competency and document performance evaluations
- Determine patient satisfaction with care provided by the extender
- Ensure that newly hired extenders undergo orientation of the practice
- Do not delegate clinical responsibilities outside your scope of practice
- Provide disclosure language in patient authorizations or consent forms indicating that physician extenders will render treatment
- Conduct performance evaluations for all extenders
- Delineate in written guidelines and protocols, how often the physician must see the patient and when the supervising physician must personally assess the patient.
- Promptly notify insurance carriers of extender staffing changes
- Foster open communication to encourage guidance
- Ensure that the physician sees patients at defined intervals
- Document all communications between physician and extender
- Monitor prescription practices
- When used, keep clinical guidelines up-to-date
- Observe the limits of delegated duties
- Ensure the projection of a professional demeanor
- Verify an applicant's credentials and prior experience as thoroughly as you would a Remain current and comply with extender licensure requirements, the scope of practice, and supervisory limitations
- Prepare written protocols that specify the extender responsibilities relative to examinations, assessments, diagnoses, treatment, and administrative functions.
- Establish criteria for periodic review and evaluation of extender medical record documentation
- Require that non-employed extenders carry professional liability insurance with coverage limits at least equal to your own or that of the practice
- Provide written notice to patients that extenders work collaboratively with the physician, who is ultimately responsible for treatment decisions. Assure patients that they will be seen by a physician when they or the doctor feel it necessary.

FAQ for Mid-Level Practice

Q: What are the legal requirements for the supervision of a physician assistant (PA)?

A: PAs are no longer required to work under the supervision or delegation of a physician. PAs are required to work with a "participating physician" based on the terms of the "practice agreement" (MCL 333.17049).

Q: What is a Participating Physician?

A: Under MCL 333.17049, a participating physician is a physician selected by a group of physicians to represent the group/practice.

Q: What is a Practice Agreement?

A: A practice agreement is a written agreement between a PA and a "participating physician." The agreement entails the communication and decision-making process by both parties to provide medical care to patients. The practice agreement also places conditions on specific duties, procedures, and medication.

Q: What is required within a Practice Agreement?

A: MCL 333.17547, requires the following items in a practice agreement:

- "A process between both parties regarding communication, availability, and decision making when it comes to medical care for the patient.
- For consultations, an alternative physician is needed when the participating physician is not available.
- Signatures for both the PA and the participating physician.
- A termination provision that allows either party to terminate the practice agreement and provide a notice of 30 days before the agreement is terminated."

The Michigan Academy of Physician Assistants has a Practice Agreement Model available for download.

Q: How many PA's can enter a practice agreement with a participating physician?

A: MCL 333.17049 eliminates the previous PA to physician ratio. Disciplinary actions will be made by the Board of Medicine, Board of Osteopathic Medicine, or the Podiatric Board of Medicine if the number of PAs per physician exceeds the reasonable standard of practice threshold.

Q: Does a physician have to review and countersign physician assistants charting?

A: According to MCL 333.17049, a physician does not have to review and countersign a PA's charting. It is recommended that physicians and clinics that employ PAs should routinely review a reasonable percentage of the PA's charts from the standpoint of quality assurance.

Q: Are PA's allowed to prescribe medications without a physician?

A: According to MCL 333.17708, PA's are considered independent prescribers and should be stated within their practice agreement. This law also includes physicians, dentists, veterinarians, optometrists (limited to therapeutic pharmaceutical agents), and APRNs (excluding schedule 2-5 which must be delegated by a physician according to MCL 333.17211a). PAs who will be prescribing controlled substances must obtain their Controlled Substance License (CSL) and maintain their DEA license.

Q: Are there any limitations on the drugs that a PA can prescribe?

A: Michigan law prohibits PAs from prescribing medical marijuana and abortive drugs.

Q: What are the legal requirements for the supervision of a nurse practitioner (NP)?

A: For an NP, state law requires supervision, delegation, or management by a physician for an NP to provide patient care. An advanced practice registered nurse (APRN) can work independently, without delegation and supervision of a physician. An APRN can perform any task considered within the Code's definition of an RN and any specific tasks meant for an APRN.

Q: What tasks can an APRN perform independently?

A: Under Public Act 499, an APRN may perform the following tasks independently:

- Write a prescription for a non-scheduled prescription drug. (MCL 333.17212)
- Provide notice of HIV test results and counseling to marriage counseling applicants. (MCL 333.5119(3))
- Make calls or go on rounds in private homes, public institutions, emergency vehicles, ambulatory care clinics, hospitals, intermediate or extended care facilities, health maintenance organizations, nursing homes, or other health care facilities. (MCL 333.17214)
- Prescribe physical therapy services. (MCL 333.17820(1))

- Refer a patient to a speech-language pathology pathologist for assessment, treatment, therapy, and services related to swallowing disorders and medically related communication disorders. (MCL 333.17607(3))
- Order/authorize physical and chemical restraints. (MCL 333.20201(2)(1))

Q: Does a physician have to review and countersign an NP and APRN's charting?

A: A physician does not have to review and countersign an NP or APRN's charting. It is recommended that physicians and clinics that employ NPs or APRNs should routinely review a reasonable percentage of the NP's and APRN's charts from the standpoint of quality assurance.

Q: Can a mid-level provider have hospital privileges?

A: Many mid-level providers have privileges at local hospitals. The scope of privileges varies from hospital to hospital.

Q: What liability does a physician have in working with a mid-level provider?

A: The available national and state malpractice data does not suggest that employing, sponsoring, or supervising a mid-level provider is a significant liability risk to a physician. If the physician is the mid-level provider's employer, the physician is vicariously liable for the acts of the employee. If the physician is not the employer but sponsors or supervises a mid-level provider, the physician may have minor liability exposure on the issues of delegation, supervision, or oversight of the mid-level provider. In some cases, the physician does not employ, sponsor, or supervise the mid-level provider, but merely consults, accepts patients from, or refers patients to the mid-level provider. For these cases the physician's minor liability exposure is the same as that of working with any other health care provider in caring jointly for a patient.

Q: How are mid-level providers covered for malpractice?

A: At this time MPIE does not write individual professional liability policies for independent mid-level providers. Policies for insured physicians and clinics cover, at a premium charge, the mid-level providers they employ.

Physician extenders have been used successfully in many practice settings. With care given to hiring practices, proper credentialing, clearly defined job descriptions, policy and procedures and quality review, you can feel comfortable that you are taking steps to mitigate potential risk.

Subscribers employing physician extenders should also take appropriate steps to

verify that adequate insurance protection is in place. The physician extender will have direct liability exposure as well as creating vicarious liability exposure for the employing physician.

Resources:
MPIE Webinar: Maximizing Effective Practice Among Physicians, PAs, and APRNs

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Tips for Supervising Physician Extenders

1. **Verify** licensing and certifications before hiring and **do a background check.** Be diligent in credentialing physician extenders, utilizing a system as rigorous as that used in credentialing physicians.
2. Always inform and **give patients a choice** when they are being scheduled with a physician extender.
3. To avoid any patient mis-perception as to the role of the extender, **proper identification (name tags)** including provider credentials (PA-C, NP) is necessary.
4. Develop clearly defined job descriptions that **defines the physician extenders role** using material obtained from the various licensing boards, with corresponding policies and procedures. Educate staff on the role as well.
5. Establish patient categories that should be seen by the physician. **Any uncertainty** by the extender as to patient status should be **physically seen/examined by the physician.**
6. Give attention to the availability of a physician in your setting.
7. **Respect the restrictions** of the physician extenders range of practice.
8. **Discuss regularly** with the physician extender, their role and expectations within the practice.
9. **Regularly review the charts** of patients seen by the physician extender. Institute a process for quality review that is helpful in discovering problem areas before they develop into sources of liability
10. **Cross check** the physician extenders **duties with the regulatory requirements.** Acquaint yourself thoroughly with the roles and responsibilities of advanced practice nurses and physician assistants according to state law. MPIE recommends contacting the State Boards of Medical Examiners, the State Boards of Osteopathic Examiners in Medicine and Surgery and the State Boards of Nursing to receive information about current licensing and credentialing requirements. Only when these roles are clearly understood can the clinician begin to “risk manage” the associated liability.

Practice Management-Shared Wisdom & Resources

Regardless of whether you are new to practice management or not the following section is offered to provide resources to enhance the skills required for successful practice management.

The first step in successful practice management is to obtain the physician's support for the decisions made regarding the staff, and the physicians must agree to refer staff back to the manager if they question decisions. Physicians should be consulted and advised on staff management, but ultimately, the manager should be left to deal with the day-to-day issues relating to staff changes/behavior.

Seven Tips for Management Success - this is an excellent place to start.
http://humanresources.about.com/cs/managementissues/qt/mgmtsuccess.htm

Employee Management in the Workplace:
http://humanresources.about.com/od/managementandleadership/u/manage_people.htm

Genius Zones: This article talks about **finding the talent or Genius Zone in the employee** and nurturing that skill-- the concept of putting your people in the right seat on the bus-- i.e., giving them job/duties that they will be successful at "What great managers do is assess each individual's talents and skills. They then provide training, coaching, and development opportunities that will help the person increase these skills. They compensate for or manage around weaknesses."
http://humanresources.about.com/od/managementandleadership/a/great_managers.htm

Walking Your Talk: A fundamental concept -- there is a whole book on it by the same name—basically, you must be an example of what you espouse your staff to be -- your actions/attitudes set the tone and model for your team-- are you open to and embrace change? If yes, so will your staff and it will be easier to make improvements.
http://humanresources.about.com/cs/managementissues/a/walktalk.htm

Encourage and Develop a Just Culture - one that is fair and supportive of employees when an error occurs. Be ready to look at the systems in the office and how they may have failed the employee and allowed the error rather than moving to a blame and shame action. The blame and shame culture is very prevalent in

medical office settings. Staff are being fired for errors “because someone has to pay.” This philosophy is destructive and will create a fearful environment. One where staff will cover up medical or administrative errors rather than share near misses or good catches in order to correct a system failure and/or ensure it does not happen to someone else with an adverse outcome.

The Center for Patient Safety (CPS) recognizes Just Culture as something that is necessary for all healthcare organizations.
https://www.centerforpatientsafety.org/just-culture/

Open Door Policy: Along with Just Culture -- goes the concepts of the “open door policy”, teach it and live it. The purpose of an open-door policy is to encourage open communication between all employees. When a company provides an open-door policy, employees feel free to talk to the manager at any time this provides a sense of trust within the organization. Having an open-door policy is useful when it comes to employees sharing their concerns or information regarding the organization; this allows management to make changes within the workplace.

Include an open-door policy in the employee handbook so that employees know that it is an option available to them.

How to create an open-door policy: https://www.thebalancecareers.com/open-door-policy-sample-1918913

Doing little things like writing thank you notes to your staff either when they have achieved some goal, gone the extra mile when needed or regularly - to reinforce that you value them and their contribution to the team.

Below are little things that can be done within the organization to show your staff how much you appreciate them:

1. Ask them what they need, e.g., “How can I help?”
2. Coach them to discover choices
3. Recognize their small incremental wins
4. Thank them
5. Demonstrate your confidence in them
6. Use “stretch assignments”
7. Help them get recognized by others

Understand the annual evaluation process 1. Evaluations must be done and 2. They are not to be a time when you unload a year’s worth of mistakes and shortcomings. Managers should do some reading on how to make evaluations a time of celebration. Where you can praise staff for all they do correctly and use the time during the year to work on improvements and growth. The evaluation is the time when you reflect back on that growth and learning to promote more of those

behaviors -- good reinforcement.

Some ways to make the evaluation process successful for employees:

- Have the employee do a self-evaluation. It allows the employee to reflect on their job performance and the contributions that they have made for the organization
- Goal setting
- Solicit feedback from co-workers that work directly with the employee.

Understand How People Communicate: Your job, as a manager or team leader, is to be able to communicate with everyone, by mirroring their verbal communication style, the pace of their speech and their intonations (unless they are offensive). It is a people skill imperative.

Communication for Workplace Success: It is important to know how to effectively communicate. This source will allow you to review the top 10 effective communication skills.

Identify Staff Behavior Styles: Another skill similar to the one above about finding the genius zone in each employee involves knowing your staff and how they communicate/behave so you can modify your communication/behavior style to fit theirs for effective communication to occur. Doing a teambuilding event where the manager can have staff self-identify style may enhance communication/behavior styles for all the team -since they will understand each other's styles and are better able to interact with one another - including the manager's style. The manager may also attempt to identify the styles on their own by using the definitions and assigning the style to each employee and then matching her style to that employee when interacting.

The DISC profile is one common tool used to distinguish different behavioral styles. Below are the breakdowns of the DISC profile.

- **D**ominance: person places emphasis on accomplishing results, the bottom line, confidence. (See the big picture, blunt, accepts challenges, straight to the point)
- **I**nfluence: person places emphasis on influencing or persuading others, openness, relationships. (Shows enthusiasm, optimistic, likes to collaborate, dislikes being ignored)
- **S**teadiness: person places emphasis on cooperation, sincerity, dependability. (Doesn't like to be rushed, calm manner/approach, supportive actions)
- **C**onscientiousness: person places emphasis on quality and accuracy, expertise, competency. (Enjoys independence, objective reasoning, wants the details, fears being wrong)

Personnel Policy

Developing policies for anticipated problems is much more effective than making decisions once the problem arises. It is necessary to set specific policies and procedures for the staff and to include them in a personnel manual. For example, it is easier to determine a fair policy for extended sick leave in advance than to wait for an employee to have a prolonged illness. Personnel policies should address federal regulated policies, e.g. Family Leave Act, overtime laws, OSHA requirements, or others.

Hiring Practice

Each prospective employee should be asked to complete an application for employment. The physician is responsible for assuring that all employees have experience or training and appropriate credentials for the positions for the position. Consequently, prospective employees must be appropriately screened before they are being hired.

Criteria include verification of education and licensure and the existence of any suits or formal complaints of record arising within the scope of prior professional activities.

An applicant should not be hired without checking references. At the very minimum, the physician should communicate with two previous employers.

Make the reference check by phone, rather than by letter. Previous employers will tend to provide more information on the telephone. Any hesitation in answering questions about an applicant's performance or ability may be a red flag. Be aware though that corporations frequently give out only dates of employment and no references.

The reference check should include the following specific questions:

- How long did you employ the person?
- When did the person leave?
- Why did the person leave?
- What did the job involve?
- Were the duties performed to your satisfaction?
- How did the person handle interpersonal relationships?
- Was the person punctual?
- Was absenteeism a problem?
- Did family or personal matters affect work performance?
- Did the person handle money for you? Was the person bonded?
- What were the person's best and worst qualities?
- Would you rehire the person?

These questions may lead to other questions. In some instances, the answers to these questions can be compared with the applicant's answers for accuracy. A reference check might only take a few minutes, but they are minutes well spent since they reduce the chance of making a serious hiring mistake.

Resource: Pre-Employment Inquiry Guide

Staff Credentialing/Background Checks

It is highly recommended that the practice performs a background check on all new hires. This type of background check should include criminal activity and financial history. Depending on the findings you may not wish to offer employment to a candidate with a criminal history as this may affect the practice's ability to participate with government-funded health care plans. Candidates found to be in financial straits or bankruptcy may not be suitable for positions related to financial management matters in the practice.

Introductory Period

Even with all the efforts described above, the physician can never really be sure of an interviewee's work habits until that person is an employee. Because of this uncertainty, it is vital that a probationary period is established, preferably for three to six months. This probationary period provides an opportunity for evaluation of the employee's performance and sets a goal for a meeting with him or her to discuss job performance.

If the office is an employer "at will" there is no introductory period. An "at will" employer can terminate an employee at any time for any reason.

Job Description

Develop job descriptions for all staff, so they understand that their roles and responsibilities are clearly defined. Employees should only be assigned tasks within their practice boundaries as defined by the Rules and Regulations of the Michigan Department of Consumer and Industry Standards. Only physicians, physician assistants, and advanced practice nurses can assess, diagnose and prescribe medications and treatments. An RN can assess, plan, implement, and educate patients. An LPN can function only under the direction of an RN or a physician. Medical Assistants (MA) can perform tasks for which they are trained under the direction of an RN or physician. Any staff can perform a task under the direction of a physician provided they had in-service training. Radiology functions should only be performed by licensed radiology staff. Personnel should review their job description periodically to maintain accuracy. Job descriptions should also reflect the level of access to protected health information required for each position.

Employee File

Two separate files need to be established, one for work practices and another separate file for the employee's employment-related health records. Both files must be maintained confidentially. Note also that if any of your employees are also patients of your practice, no portion of their clinical chart or medical record should be kept in an employee health file. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that records of employees who are also patients be treated exactly like the records of any other patient. MPIE advises caution with this dual role of employer and healthcare provider as the relationship can be complicated by HIPAA privacy rules, special treatment, and conflict of interest issues. See the resources section below for more information on this topic.

A personnel work file should include the following information for each employee:

- Formal application.
- Note that telephone references were obtained.
- Verification of licensure and a copy of the current license.
- If applicable, a copy of the practitioner's DEA registration.
- Documentation of orientation to the office.
- Signed statement of confidentiality.
- Checklist or similar documentation of the person's ability to perform specific procedures.
- Verification of in-service training for a task outside the person's usual job role.
- Copies of all certificates from continuing education programs.
- Withholding forms for local, state and federal taxes.
- Copy of social security card.
- Copy of driver's license.

A personnel health file should include the following information for each employee:

- Individual to contact in the event of an emergency.
- Statement regarding health and vaccination status.
- Occupational exposure incidents.

Orientation

A formal orientation should be provided to each new employee. This includes all full-time, part-time, and temporary personnel. The orientation should include education regarding confidentiality issues. A checklist could be developed based on the job description to ensure that all necessary information is provided to the employee. The orientation should be documented by both the new employee and the office manager signing and dating the orientation document and placing it in the employee's file. Other topics to include in the orientation include, but are not limited to:

- Employee Disciplinary Action.
- OSHA/CLIA Guidelines.
- OSHA training within required timelines.
- Training on Equipment.
- Training on performing procedures/assisting the physician in performing procedures.
- All forms used in the office.
- Job Description Review.
- HIPAA Compliance.

Employee Education

Staff should be encouraged to attend programs and workshops directly related to their job. It is essential to create a culture of accountability to ensure that the organization is providing continuous education to staff. Provide lists of medical terms and abbreviations to prevent errors. Educate staff on significant symptoms in your specialty and what is urgent, emergent, and STAT. Office staff meetings can also incorporate educational programs.

Topics of programs that could enhance employee performance include basic cardiac life support, communication skills, and stress reduction. Specific topics must be revisited on an annual basis to meet regulatory requirements, which include hazardous materials, universal precautions, safety action plans, and HIPAA Compliance. The State of Michigan Consumer Industry Services (CIS), Board of Nursing requires that all RN's and LPN's acquire 25 continuing education hours every two years. Copies of the continuing education certificate should be kept in personnel files.

Sources of educational programs used effectively for physician office staff include videotapes available from the hospital, public and university libraries and professional organizations. MPIE provides yearly educational opportunities as part of the Loss Prevention Program. Office staff and physicians should be encouraged to participate when appropriate.

Confidentiality

As part of one's promise to give patients the highest quality health care, it is necessary to keep information about their health confidential, sharing it only with people who need the information to do their jobs. Until now, this promise was simply part of a code of ethics. However, under the Health Insurance Portability and Accountability Act (HIPAA), effective April 2003, it is illegal to violate this code. HIPAA regulations include civil and criminal punishments for anyone caught violating patient privacy.

Civil penalties are fines of up to $100 for each violation of the law per person to a limit of $25,000 for each identical requirement. For instance, if your office practice released ten patient records illegally, it could be fined $100 for each record, for a total of $1,000. If you illegally released ten records to two different parties, the fines would rise to $2,000.

Criminal penalties can include not only hefty fines but also jail time. Selling patient information is more serious than accidentally letting it be released. These penalties can be as high as a $250,000 fine or a prison sentence of 10 years.

There are several ways that office staff can protect patient confidentiality. Focus attention on the bits of confidential information that slip out when other patients overhear private conversations Reasonable steps must be taken to minimize the risk of such disclosures of information. Particular attention to the location of office phones will help protect privacy. Position computer screens so that other patients cannot see the information. Information contained in the computers is as confidential as the information in the patient's medical record. Employees should not be looking up information on patients on the computer unless that information is specifically needed to their job. Knowledge of patient information remains at work. Staff members should refrain from discussing patient information with each other unless this information is necessary to provide patient care or services. In other words, information sharing among office staff members in a non-work setting or with family members at home or anywhere should be strictly prohibited.

New patient-written questionnaires prevent personal information from being repeated within the hearing distance of a roomful of patients. The questionnaire could be mailed ahead to all new patients, along with a new patient letter, which includes specifics regarding office location. Leaving charts, reports, patient information, x-rays, office schedules, or similar items out in the open where patients can view them is prohibited.

Under HIPAA and perhaps under state law, a physician can be held liable for an employee's breach of confidentiality. Physicians and nurses who deal with medical issues daily may view private information differently from the patient. It is the patient's viewpoint that counts. Employees should receive a written statement that each must sign, at the time of orientation explaining the confidential nature of the information they may learn about patients, along with policies against unauthorized disclosure of information. This statement should be reviewed and signed annually. Employees should attend both HIPAA and OSHA in-service training.

E-Signatures for Electronic Medical Records

In the event of a malpractice lawsuit where there is a question as to who created an entry, it is important to have access to the e-signatures in the EHR system. An

e-signature displays the users' name, credentials, date, and time of the signature. Using an e-signature can also restrict the number of staff members that can be called by a plaintiff attorney for a deposition when an entry in question is unsigned or illegible.

Guidelines for using electronic signatures

1. Systems and software must include protections and apply administrative safeguards that correspond to standards and laws.
2. E-signatures should be limited to individuals with privileges to document in the medical record, such as treating physicians, clinicians, healthcare staff, and clinical residents and students.

Termination of Employment

When a relationship with an employee is no longer beneficial for the practice or puts patient safety at risk, it is time to terminate the employment relationship. There are abundant concerns around employment termination including the Americans with Disabilities Act and wrongful termination suits. MPIE recommends consulting with legal counsel if the practice has any concerns when terminating an employee.

Resource: 10 Things You Should Never Do When Firing an Employee

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#12: Safety Practices/General Liability

General Liability Prevention

The most frequent general liability claim in the physician's office involves a patient or visitor who has tripped, fainted, or fallen and sustained injury. The second most frequent claim is related to lost property, especially in Ambulatory Centers where operative or diagnostic procedures are offered.

As with any business, physician practices have a duty to provide a safe environment for employees, patients, and family and friends who accompany patients. Local, state, federal, and environmental protection regulations must be followed.

Local, state, federal, and environmental protection regulations must be followed. Employers who fail to provide a safe workplace or fail to comply with health or safety regulations may also be penalized or fined through regulatory agencies.

Ensuring the safety of the physical facility can be a formidable task. Fire safety, electrical hazards, hazards from compressed gases, construction safety, safety in the wake of natural and man-made disasters, and indoor air quality are all safety issues related to the physician office facility.

It is important to know what company provides coverage for general liability injuries at your practice before they occur. MPIE does provide this coverage in all cases. Ensuring safe premises may be complicated by shared responsibility with a landlord, a real estate management company, or other building occupants. Depending on building ownership and/or lease agreements, information regarding problems with facility safety may need to be communicated to an outside party for correction. If the physician's office cannot get the owner to eliminate or abate certain hazards, legal counsel should be consulted.

Office Safety Review

Periodically, an office safety review should be conducted to assess the overall safety of the environment. Areas to be reviewed could include:

Parking and Building Access

- Be sure handicapped parking is available which meets city code requirements.
- Have a wheelchair entrance and a wheelchair available if needed.
- Parking lots and walkways should be in good repair (no potholes, obstructions, etc.).
- If the practice is open in the evening or early a.m. hours in the winter, the parking lot and entry should have appropriate lighting.
- If the practice has more than one entrance, signage should be appropriate and patient entry easy to locate.
- A practice intrusion alarm system is recommended.
- Dead bolt locks or other security measures are important.
- Access to the building after hours should be appropriately limited.

Waiting Room and Hallways

- Halls should be kept free of clutter.
- The waiting room should be comfortable and contain adequate seating.
- Be sure the environment, including plants, is safe for children.

Exam Rooms

- Check to see that the number of exam rooms are adequate for your practice.
- They should be comfortable and have adequate lighting, heating, and cooling.
- A privacy area or curtain for undressing/dressing is recommended.
- A call button in each room for emergency assistance is important.
- Basic diagnostic and emergency equipment should be available in each

room.
- There should be “sharps containers” in each room which are placed outside of the reach of children.
- Have adequate waste containers including one designated for hazardous wastes.
- Have step stools available to assist patients with getting on/off exam tables.
- Keep medications, scalpels, syringes, etc. secured in cabinets or in such a manner that they are not in plain view of patients and/or children.

If your facility serves hot beverages, the beverages should be in approved heat resistant/melt resistant cups with lids. Depending on your patient clientele, as to their medication, mental status, and gait, and overall determination as to whether you allow or offer self-serve coffee stations should be made.

In the event you do have an injury on your premises you should first assist the injured person. It is appropriate and recommended that a physician provide a quick exam of the injured person and provide care as appropriate (ice bag, band-aids, smelling salts, etc.) and to recommend they be seen in the emergency room and arrange the appropriate transportation including calling 911.

Once the injured person has been assisted and is stable it is now necessary to notify the appropriate entity or person and complete an incident report (we have included a sample form in this manual in the event your general liability insurer does not provide you with one). You may be required to provide evidence, take photos, or complete forms at the time of the injury depending on the requirements of your carrier. Know the requirements of your carrier ahead of time!

It is recommended that you be able to quickly identify the appropriate entity and person to call to report the injury. We have included a form to assist you in obtaining this information ahead of time so it will be ready and available to you in the event you need to locate it after an injury.

Resources:
Sample General Liability Contact Form
Sample General Liability Incident Report Form

Equipment Maintenance

A safety program for equipment has as a basis the commitment of the practice that only equipment that meets the standards of the medical community is used. The equipment is maintained and used according to the recommendations established by the manufacturer and the federal government.

A list of all equipment that is owned and leased should be compiled and updated as

new equipment is added. This list could include:

- Name of equipment.
- Serial number.
- Next scheduled service check or maintenance.
- Name and telephone number of service provider.

Each individual piece of equipment should also have a separate record that provides the following information:

- Type of equipment.
- Brand name.
- Manufacturer.
- Date of manufacture.
- Purchased or leased, including date and vendor name.
- Documents available, e.g., receipt, warranty, and procedure manual.
- Service agreement for preventative maintenance.
- Record of service history.
- Staff training record (document whether the manufacturer and/or office staff provided the training).
- Record of any recalls.

A system should be developed to review and renew service agreements for preventative maintenance of equipment on an annual basis.
Contracts should include the following elements:

- Responsibilities of both parties for the use and maintenance of the equipment.
- Terms regarding any needed replacement of parts or equipment.
- Effective dates and expiration dates.
- Hold harmless agreement and indemnification clauses.

A procedure should outline the steps to be taken if a piece of equipment breaks, is defective, or does not function properly.

The equipment should be tagged and removed from service. The tag should document the problem, date, and time of removal from service.

**If a patient is injured as a result of the use of equipment, personnel should sequester (remove from service and lock up) the involved equipment.
The Practice Manager should be notified, and the equipment should not be released to the manufacturer or repaired until instructed to do so. Contact MPIE claims immediately so that the necessary next steps may be taken to inspect the equipment and determine potential causes that resulted in the injury. Failing to handle equipment involved in a patient injury in this manner could jeopardize the potential for a strong defense in the event of a claim.**

Electrical Safety

An electrical safety program should require that equipment be used in accordance with the manufacturer's specifications. If applicable, equipment should be grounded.

In the event of a power failure, fire, or other disasters, battery-operated wall-mounted emergency lights in the corridors and by exits should be in place to permit the safe evacuation of patients and personnel. In lieu of battery-operated lights, an adequate number of flashlights can also be used. In any event, all batteries must be checked at regularly scheduled intervals.

All electrical outlets should be covered with child tamper-resistant plugs. Even if your practice does not treat children, patients will often bring children in that are in their care. Your practice has a responsibility to provide a safe environment for all who may enter.

Fire Safety

Every physician office should have a fire safety program that includes components for fire prevention, fire detection and warning, extinguishing fires, and facility evacuation.

- Each office practice should have a written fire safety policy. The policy should be periodically reviewed and practiced by everyone.
- Fire drills should be conducted regularly so that all staff know what to do to protect both their safety and that of the patient in the event of a fire.
- A fire and emergency evacuation plan should be developed and posted for each physician office site.
- Fire exits should be clearly marked.
- Fire extinguishers should be in working order, periodically tested, and easily located.
- Smoke/fire detectors and sprinkler systems should be well maintained and regularly tested.
- All medical gases and flammable liquids should be properly stored.
- All staff should be knowledgeable of emergency phone numbers and access to fire, police and emergency medical services.
- All employees, including physicians, should be actively involved in identifying potential fire hazards that may exist in the office setting. Some common electrical hazards to look for include overloaded outlets, frayed cords and use of unapproved equipment (equipment that has not passed or had a recent preventative maintenance inspection such as portable space heaters, fans and radios).

Emergency Response System: Medical Emergencies

Medical emergencies such as anaphylaxis, cardiac arrest, and seizures can occur in the physician office setting. Each physician office practice is encouraged to evaluate their patient population to determine the types of medical emergencies that have or may occur and determine how to plan for such emergencies. Sometimes it makes sense to purchase equipment and/or medications that are consistent with the skills of the practitioner to manage anticipated emergencies. Emergency equipment, such as an Automatic External Defibrillator (AED) and/or medications may be necessary. For example, offices that administer certain high-risk medications should prepare to treat significant allergic response/anaphylactic shock or other known significant side effects that occur during administration. It is not typically necessary to maintain crash carts. However, offices that conduct certain tests, procedures, and/or administer sedation may need to maintain a crash cart and emergency medications. Any medical emergency equipment/measures implemented should be consistent with the needs of the patient population, the general scope of care provided, and the training, skill, and scope of the clinical staff members.

Develop a written medical emergency response plan and protocol. At a minimum:

- Prompt staff to call 911
- Outline the roles and responsibilities of various staff members (e.g., reception staff directs emergency responders to the patient, medication administration, documentation)
- As applicable, describe the available emergency equipment and maintenance schedules (e.g., testing equipment, checking for expired medications)
- List the type of certifications or training that is required for clinical team members (e.g., BLS, ACLS)
- Provide documentation guidelines
- State the scope and frequency of staff training and drills
- Outline the debriefing process

Depending on the type of services that are provided, the medical emergency response plan and protocol may be more extensive.

Disaster Plan/Weather Emergency

A written disaster plan should address action to be taken in the event of a fire, tornado, or other natural disasters. The safety of employees, patients, and visitors must be the first concern in planning. The plan should include procedures for evacuation and periodic drills. There should be an evacuation map on a prominent wall in the office.

No one emergency plan can be applied to all offices. Each office must therefore

decide on a plan that fits its needs. You may wish to start with an analysis of your areas of vulnerability. This analysis may be done with a team and depends on the practice size and variety of services offered such as radiology or lab as those areas will require representation in the planning team. Begin by performing an analysis of the effect of a wide variety of disasters on your office setting including patient safety, staff safety, the safety of the physical plant, and protection of valuable medical and business records.

Once you have done the analysis and identified risks and how prepared you are to handle them you can prioritize the events that might affect your setting.

Commit Your Plan to Writing

- List the various types of disasters that might directly impair the operation of your office (e.g., tornado, flood, earthquake). Describe what you will do to address each issue identified, and who will carry out those functions.
- The written plan should be used to communicate to all levels of staff and those outside your organization that may be impacted.
- Provide staff with the training and tools necessary to implement the plan.
- Review and update your plan at least annually.
- Conduct drills at least semiannually.
- If you need outside help with your plan, consider local resources such as your fire department, nearby hospitals or public health department.

Part of your disaster plan should include an evacuation plan.

See Section 13 of this manual for additional information on Disaster Plan.

Hazardous Materials

Follow accepted Center for Disease Control, OSHA, and the Michigan Department for Environmental Quality guidelines on storage, handling, and disposal of toxic and hazardous materials including needles, syringes, and blood products.

Material Safety Data Sheets (MSDS) are available from the manufacturer for hazardous medications and material. A copy should be on file for each physician office practice location. A written policy describing the Hazard Communication Program is advised.

Medication and sharps safety

Medications, needles, and syringes should be stored away from patient examination rooms and secured in locked cabinets or medication dispensing systems. Sharps disposal units should be secured and placed conveniently in areas of sharps use.

Refrigerated medications should be stored at the proper temperature and logs

maintained per requirements. The expiration dates for refrigerated medications should be checked before administration and documented in the patient's medical record along with the date, name of the medication, dosage, and mode and location of administration.

Mandatory Reporting Abuse or Neglect

The Michigan Child Protection Law requires that certain persons report any case of suspected child abuse or child neglect to the Michigan Department of Health & Human Services (MDHHS). The definition of mandated reporter includes physicians and nurses and many more licensed professionals.

The Legal Standard for Reporting Child Abuse or Neglect

The Michigan Child Protection Law requires you to file a report when you have reasonable cause to suspect abuse or neglect. This is an extremely low legal standard. The pamphlets available from MSU Chance at Childhood Program describe some signs of abuse and neglect. However, you must keep in mind that you are not required to determine whether abuse or neglect has actually occurred. DHS is responsible for investigating reports of suspected abuse and neglect and for determining how each case progresses. You must make a report whenever you suspect that abuse or neglect may have occurred. A report may be filed by filing out a DHS-3200 Form. If a mandated reporter is dissatisfied with the response by MDHHS, the mandated reporter may contact the Mandated Reporter Hotline at 877-277-2585. Prior to doing so, the mandated reporter must first attempt to talk with the local MDHHS office director about their concerns.

Resources:

Mandatory Reporter Pamphlets

Department of Human Services Mandated Reporter web site at Michigan.gov

MSU Chance at Childhood Program: http://chanceatchildhood.msu.edu

DHS-3200 Form can be requested from the local DHS office and can be accessed at:

www.michigan.gov/dhs or www.michigan.gov/documents/FIA3200_11924_7.pdf

Abuse of Incapacitated or Vulnerable Adults

Several State statutes provide guidance on reporting duties in the event of suspected abuse of an adult (see the statutes cited at the end of this paragraph). Information on elder abuse reporting duties is not as clearly disseminated as is the child abuse duties – but it still exists. Reporting of the abuse of elderly or vulnerable adults is mandated in some fashion in most states. In Michigan any physician, registered nurse practitioner, hospital intern or resident, surgeon, dentist, psychologist, social

worker, police officer or other person who has responsibility for the care of an incapacitated or vulnerable adult and who has reasonable basis to believe that abuseor neglect of the adult has occurred or that exploitation of the adult's property has occurred shall immediately report to a police officer or to an adult protective services worker. (MCL 400.11a,MCL 400.11e, MCL 328.1931-xxa, MCL 333.21771)

The report may be made to: Adult Protective Services Hotline 1-800-996-6228, or Kent County Adult Protective Services at 616-248-9600.

The specificity of laws varies from state to state, but broadly defined, abuse may be:

- Physical Abuse - Inflicting, or threatening to inflict, physical pain or injury on a vulnerable elder, or depriving them of a basic need.
- Emotional Abuse - Inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts.
- Sexual Abuse - Non-consensual sexual contact of any kind.
- Exploitation - Illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable elder.
- Neglect - Refusal or failure by those responsible to provide food, shelter, healthcare or protection for a vulnerable elder.
- Abandonment - The desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.

Resources: DHS Adult Protective Services, Reporting Elder Abuse

Voluntary Reporting

Department of Motor Vehicles

Notwithstanding the physician-patient relationship, a physician, psychologist (and in some states a substance abuse counselor) may voluntarily report a patient to the Department of Motor Vehicles who, in the opinion of the physician or psychologist, has a medical or psychological condition that could significantly impair the person's ability to safely operate a motor vehicle. If you believe a patient cannot safely operate a motor vehicle, from a risk management perspective, it is suggested that you discuss with the patient, the risk of driving and document that warning. Contact your state department of motor vehicles office to determine what, if any, reporting obligations you may have regarding the patient. If possible, involve family members during patient visits, and document discussions against driving to family members as well as to the patient.

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#13: Disaster Plan

A written disaster plan will help guide actions to address a catastrophic event that disrupts the entity's business and medical practices. A disaster may include a fire, weather event, hazardous material event, earthquake, bomb threat, pandemic, or medical emergency.

The plan should outline the entity's approach to emergency management. The elements of your plan should include the following, at least:

- A list of related policies to address specific threats (sample policy language for a variety of specific threats has been provided)
- Communication
- Evacuation routes plan
- Post-disaster huddle and checklist (damage assessment, status of employees, medical records access, financial resources, information processing, office space needs (temporary/permanent), immediate equipment needs, contacting patients and suppliers)
- Business interruption/continuity plan
- Scope and frequency of mock codes and drills

Ensure that all staff members are familiar with the organization's disaster plan and personnel roles are known. Guidance on addressing the above elements are outlined below.

Policies to Address Specific Threats

Develop policies to outline the management of threats, evacuation routes, procedures for orderly evacuation and other threat-specific elements. Several sample policies have been provided below and the examples are not reflective of comprehensive customized policies to cover all potential disasters. Evaluate your own environment to determine additional potential disasters and develop customized polices to guide response. Refer to these policies in your disaster plan.

Sample Policies

The sample policy elements should be customized to meet the unique needs of your organization. For example, list the title of designated individuals who are responsible for specific tasks, outline/include a map of the evacuation route, and describe the procedures for patient, staff and visitor evacuation.

Bomb Threat Sample Policy

Purpose: To outline actions to take in response to a bomb threat to address the safety of patients, personnel and visitors.

If a staff member receives a bomb threat:

- Remain calm
- Ask the caller for details regarding the location of the bomb and detonation plan.
- Listen and make note of voice characteristics, accent, background noise and other information that may provide important information about the caller.
- Immediately notify the office manager/designee and police to relay the information provided.

Office manager or designee shall initiate the evacuation plan. During the evacuation, do not disturb the environment (e.g., do not touch anything, do not move anything that looks out of place, do not turn on/off lights).

If a suspected bomb is found, make note of the location and provide police with a description of what you observed and the location of the device.

Fire Response Sample Policy

Purpose: To outline fire prevention and fire response plan

Fire Prevention

- Designate who is responsible for maintaining fire extinguishers, sprinkler systems, and fire alarms.
- Schedule, at least annually, fire drills and personnel training on the use of fire extinguishers.

Conduct regularly scheduled environmental rounds to inspect equipment and electrical cords for potential fire hazard. Ensure that all exits, hallways and doorways are clear of obstructions.

- Engage your local fire department to assist with your fire prevention process.

Fire Response Plan

- In the event of a fire:
  - Pull the fire alarm
  - For small contained fires, attempt to extinguish the fire with a fire extinguisher and call 911For large fires that cannot be controlled with a fire extinguisher, call 911
  - Initiate evacuation plan

Tornado

Purpose: To outline preparedness for a tornado and actions to be taken when there

Preparedness:

- Determine the safest place in the building (e.g., designated shelter), such as basement, interior hallway, or small interior room.
- Conduct, at least annually, tornado drills that includes at least a table-top discussion regarding how to evacuate patients, especially those who may need assistance.

Tornado Warning:

- In the event of a tornado warning, a designated person shall coordinate escorting patients, personnel and visitors to the designated shelter.
- Simultaneously, other designated staff members shall ensure that all blinds and windows are closed, if there is sufficient time to do so.
- When the tornado warning is clear, a designated person shall escort patients, personnel and visitors back to the office.

Additional resource related to tornado preparedness:

- United States Department of Labor – Occupational Safety and Health Administration (OSHA), "Tornado Preparedness and Response," https://www.osha.gov/dts/weather/tornado/preparedness.html

Disaster Planning Resources:

- Michigan Department of Health & Human Services – Division of Emergency Preparedness and Response: https://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54826---,00.html
- FEMA Preparedness Checklists & Toolkits (last updated 11/15/17): https://www.fema.gov/preparedness-checklists-toolkits
- FEMA Emergency Preparedness: https://www.fema.gov/disaster/4339/emergency-preparedness
- https://www.ready.gov/
- Centers for Disease Control and Prevention (CDC) Emergency Preparedness and Response: https://emergency.cdc.gov/planning/index.asp
- Centers for Disease Control and Prevention (CDC) Planning Resources by Setting: https://www.cdc.gov/cpr/readiness/healthcare/planning.htm
- Kentucky Medical Association (KMA) – KMA Managed Care Committee and the KMA Medical Manager Advisory Group, "Model Disaster Plan for A Physician Practice."
- United States Department of Labor – Occupational Safety and Health Administration (OSHA), "Tornado Preparedness and Response," https://www.osha.gov/dts/weather/tornado/preparedness.html

Communication Plan

The communication plan addresses both internal and external communications. Review and update the list at least annually to ensure the information is current. Internal communications include a list of employee contact information. Designate an individual and alternate, by title, to initiate important disaster-related information to team members. The designated individual and alternate should maintain the updated list at home, if not available electronically. The internal communication process facilitates providing information and detailed instructions for employees. For example, weather emergency or fire resulting in immediate office closure before office hours, safe to return to work after bomb threat and so on.

Outline the procedure and mechanism to reach patients when the office has an immediate unplanned closure. Designate an individual, by title, to coordinate communications to patients. Include in the plan triage procedures to prioritize patient appointment rescheduling.

The external communication procedures should include maintaining an updated list of important organizations, such as:

- Utility company
- Local health department
- Insurance company (e.g., malpractice, property & casualty)
- Accrediting agency
- Red Cross

Ensure that the communication plan is an integral part of the annual drill plan.

Evacuation Routes Plan

Develop a customized evacuation procedure for your office setting. This will facilitate orderly and timely evacuation to a safe place. Some of the disaster policies may outline different procedures for evacuation. For example, the “Bomb Threat” policy will facilitate evacuation outside of and far away from the building. The “Tornado” policy will facilitate evacuation to a designated area within the building.

Utilize your annual drill process to test the evacuation routes outlined in the disaster plan and in related policies.

Post-Disaster Huddle

Develop a post-disaster huddle process to evaluate damage and next steps. A checklist will help guide next steps and should include, at least:

- Ongoing safety threats to staff members, patients and visitors
- Damage assessment
- Estimated timeframe to resume operations

- Status of employees (gaps, employee needs, employee ability to return to work)
- Office space needs (temporary/permanent)
- Medical records access
- Utility and technology failures and estimated timeframe for access, as applicable
- Logistics and supply management (e.g., equipment needs, supplies needs)
- Communications: Patients, suppliers and other external parties (see the "Communication Plan" section above for additional external party considerations)

Identify a team member, by title, to lead the post-disaster huddle process and coordinate the needs of the entity. Utilize the post-disaster huddle process to prioritize actions and learn for future similar events.

Business Interruption/Continuity Plan

Business continuity is the process to actively ensure that key organizational functions are available to key stakeholder. In the medical practice industry key stakeholders include patients, providers and others who are necessary to keep the business functioning. Critical disruptions may include unavailable staff, loss of utilities and water, loss of communications, and loss of access to the premises.

The business continuity plan proactively prepares the office practice to maintain operations in the event of a disaster. The first step is to develop an operations manual that provides a comprehensive description of the practice's normal business functions. Next, estimate the business impact including how long the practice can operate without the business function (e.g., one hour, one day, one week, one month). Prioritize the business continuity plan based on the highest priorities and develop a contingency plan for each critical operation.
For example, if the practice uses electronic health records (EHR) it cannot function efficiently and safely when the EHR cannot be accessed. Proactively identify a back-up plan to document patient encounters, maintain the information and later populate in the EHR.

Test the business continuity plan during disaster drills.

Emergency Disaster Drills

It is important to establish a process to regularly conduct emergency disaster drills that demonstrate the practice's response under duress and ability to respond in a timely and efficient manner.

Conduct disaster drills on an annual basis, at least. Consider partnering with community-based disaster drills that involve police, fire, health department and other

local agencies that offer emergency preparedness exercises and resources. Multiple drills may need to be conducted throughout the year, depending on the risk of the event happening in your setting or your geographical area. For example, in early Spring the practice should conduct a tornado drill.

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#14: Sexual Orientation and Gender Identity (SOGI)

Healthcare entities are actively taking measures to implement trans-competent care and promote culturally competent care to transgender and gender non-conforming (TGNC) patients. Some efforts have been prompted by regulatory agencies (e.g., U.S. Department of Health & Human Services, Office for Civil Rights, Centers for Medicare & Medicaid Services, Office of the National Coordinator of Health Information Technology) and accreditation-generated requirements. Others recognize the need to conform to societal demands for an enhanced approach to make all patients feel welcomed and respected. It is an integral component of delivering patient-centered care and ensuring that all patients receive screening and preventive care based on their gender at birth and any gender reassignment surgical procedures that may impact care needs.

Staff education and core intake procedures and gender-conforming intake forms/ EMR templates are the key to meeting this demand. The education program may be guided by regulatory or accreditation guidelines and should include, at least, a review of definitions and scripting guided role-playing for staff members to practice how to address patients.

Definitions:

Definitions of various terms have been categorized below by gender identity and sexual orientation.

Gender Identity Terminology

- **Sex:** Biological characteristics that are used to categorize individuals as male, female or intersex. It refers to the genetic, hormonal, anatomical and physiological characteristics an individual is born with.
- **Intersex:** Describes a person who is born with both sex characteristics or characteristics that do not fit typical binary notions of male or female bodies. The term “hermaphrodite” is considered outdated and offensive.

- **Gender:** Gender refers to the socially constructed characteristics of women and men, such as norms, roles and relationships of and between groups of men and women.
  - Gender identity
  - Gender expression
  - Gender dysphoria
- **Gender identity:** A person's internal sense of gender. Examples include being a man, a woman or genderqueer.
- **Gender Expression:** A person's outward gender presentation usually comprised of personal style, clothing, hairstyle, makeup, jewelry, vocal inflection and body language.
- **Transgender:** Anyone whose gender identify differs from their sex assigned at birth.
  - Transgender woman: The affirming way to refer to a person who is transgender and identifies as a woman.
  - Transgender man: The affirming way to refer to a person who is transgender and identifies as a man.
- **Cisgender:** Person whose gender is consistent with sex.
- **Non-Binary:** A spectrum of gender identities that are based on the rejection of the assumption that gender is strictly an either/or option of male or female based on assigned sex at birth. Common words individual's may use to express their non-binary gender include "agender," "bigender," "genderqueer," "genderfluid," and "pangender"
- **Pronouns:** Linguistic tools that are used to refer to people (e.g., they/them/theirs, she/her/hers, he/him/his).
- **Questioning:** Describes an individual who is unsure about or is exploring their own sexual orientation and/or gender identity.
- **SOGI:** Sexual Orientation and Gender identity. This term is used in the healthcare setting specifically for collecting data on sexual orientation, sex assigned at birth, gender identity and pronouns.

Sexual Orientation Terminology

- Sexual Orientation: Refers to an individual's sexual attraction, sexual behavior and sexual identify. Common terms include lesbian, gay, bisexual and heterosexual/straight. Sexual orientation has three dimensions:
  - Sexual attraction: The relationship between a person's gender and the gender of the individual(s) to whom that person is sexually attracted
  - Sexual behavior: The relationship between a person's gender and the gender of the person(s) with whom that person engages in sexual activity
  - Sexual identity: The way a person self-identifies with a given sexual

orientation

- **Asexual:** Describes a person who experiences little or no sexual attraction to others. This is not the same as celibacy.
- **Pansexual:** A sexual orientation that describes a person who is emotionally and sexually attracted to people regardless of gender.
- **Queer:** Formerly a derogatory term that is now widely accepted as a term used to describe people who think of their sexual orientation or gender identify as outside of societal norms.

Procedures:

Adopt procedures to obtain from the patient their sex assigned at birth, gender identity, given name, preferred name and pronouns. Document these elements in the patient's medical record and ensure that team members consistently address the patient by their preferred name and pronoun.

Sex assigned at birth

It is routine to obtain the patient's sex assigned at birth to facilitate care decisions. For example, preventative care measures include prostate exams for patients who have testicles and pap smears for patients who have a cervix.

Gender Identity

It is important to gather information about gender identify to promote a patient-centered care environment and make patients feel welcomed and accepted. Without this information, LGBTQ patients and their specific health care needs cannot be identified, the health disparities they experience cannot be addressed, and the provision of important health care services may not be delivered.

Sexual Orientation (sexual identity, sexual attraction, sexual behavior)

This information is important to make care decisions for preventative screenings, assessments of risk for sexually transmitted diseases and HIV, and effective interventions for behavioral health concerns that can be related to the experiences of anti-LGBTQ stigma.

Preferred Name

Promote inclusivity and enhance the patient-provider relationship by asking the patient their preferred name and using their preferred name and pronoun during patient encounters.

Pronouns

It's important to ask and not assume what someone's pronouns are. Recall pronouns include they/them/theirs, she/her/hers, and he/him/his. Examples of questions to ask an individual to determine their pronoun preference, include "what pronouns would you like me to use when referring to you?" or "What pronouns do you use to refer

to yourself?" If you make a mistake and call someone by a pronoun other than their preferred pronoun, apologize and correct the mistake. For example, "I'm sorry I used the wrong pronoun earlier. I'll try to be more careful next time" or "Her books are – I'm sorry, their books are over there." It can be difficult to remember pronouns at first. Practice this exercise with the office staff members.

Staff Training

Develop scenarios to test team members' knowledge and ability to obtain information about each patient's gender identity, sexual orientation, preferred name and pronoun. Test team members' ability to routinely address patients by their preferred name and pronoun. All patients should be treated the same upon in person intake or phone-based intake and asked the same set of questions listed above even if it seems to appear obvious (it may not be!).

Sample Scenario:
The patient's given name is John Smith and the preferred name is Susan. Susan prefers the pronouns they/their/them. Susan was born a man and identifies as a woman. Susan is sexually attracted to men and has sexual encounters with men only.

- *What is Susan's assigned sex at birth?*
- *What is Susan's gender identity?*
- *By what name should staff members address the patient?*
- *Insert the correct pronoun: Susan would like _____ test results.*
- *What is the patient's sexual orientation (sexual attraction, sexual behavior, sexual identity)?*

Consider expanding these questions to determine appropriate screening examinations and anticipate patient need for educational needs and mental health resources.

Resources:

- National LGBT Health Education Center (2016), "Glossary of LGBT Terms for Health Care Teams," Boston, MA: Fenway Institute. https://www.lgbthealtheducation.org/wp-content/uploads/LGBT-Glossary_March2016.pdf
- Southern Oregon University, "What are Pronouns?" https://inside.sou.edu/qrc/pronouns.html
- Centers for Disease Control and Prevention, "Collecting Sexual Orientation and Gender Identity Information," https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html
- Federal Interagency Working Group on Improving Measurement of Sexual Orientation and Gender Identity, " Current Measures of Sexual Orientation

and Gender Identity in Federal Surveys," August 2016, https://dpcpsi.nih.gov/sites/default/files/WorkingGroupPaper1_CurrentMeasures_08-16_508.pdf.
- U.S. Department of Health & Human Services, Office of Civil Rights, "Section 1557 of the Patient Protection and Affordable Care Act," https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
- Centers for Medicare & Medicaid Services, "Sexual and Gender Minority Clearinghouse," https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/hcps-and-researchers/data-tools/sgm-clearinghouse
- Katherine Steuer, Kaleigh Davis, "Respecting Gender Identify in Healthcare: Regulatory Requirements and Recommendations for Treating Transgender Patients," American Bar Association, March 2017, https://www.americanbar.org/groups/gpsolo/publications/gpsolo_ereport/2017/march_2017/respecting_gender_identity_healthcare_regulatory_requirements_recommendations_treating_transgender_patients/
- Section 1557 of the Patient Protection and Affordable Care Act (PPACA), 42 U.S.C. §18116, https://www.govinfo.gov/app/details/USCODE-2015-title42/USCODE-2015-title42-chap157-subchapVI-sec18116
- 45 CFR §92 https://www.govinfo.gov/content/pkg/CFR-2019-title45-vol1/xml/CFR-2019-title45-vol1-part92.xml

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#15: Telemedicine Risk Management Tips

Telemedicine is proving a critical tool for addressing the need to provide healthcare services for patients that are unable to travel or to be seen in person. The CDC, several state public health agencies, and numerous industry groups are promoting telemedicine as a response to this need.

Considerations for Implementing Telemedicine:

- Utilize all the risk mitigating and patient safety tools you would normally use:
  - thorough communication,
  - coordination of care, and
  - documentation of your clinical thinking and decision-making process.
- Laws and regulations have been relaxed and expanded over the past few years to facilitate greater telemedicine adoption.

- Barriers to the use of telemedicine have been reduced in response to the pandemic.
- Professional liability coverage may be affected. You are encouraged to reach out to your carrier to ensure coverage is in place for this practice.

Risk Management Tips for Providers Delivering Telemedicine Services:

- **Appropriateness** - Ensure that the patient's condition can be adequately assessed and examined via the telehealth platform.
- **Technology** - Ensure the patient has the necessary technology to make telehealth possible and effective for examining the patient.
- **Authenticate** - Ensure you are examining and prescribing for the correct patient.
  - Have the patient hold up their driver's license and compare information to authenticate identity.
  - Check insurance eligibility: confirm the patient's name, address, date of birth, and social security number.
- **Documentation** - Ensure the encounter is thoroughly documented, including all communication, orders or tests/results, follow-up recommendations, and coordination of care.
- **Confidentiality** - Document that the patient agrees and understands that there are limits of confidentiality when communicating via telehealth.
- **Technical Issues** - Document if any technical issues were encountered and interfered with the contact, including poor internet connectivity, camera malfunction, patient inability to use the technology adequately for the exam.

Risk Management Tips for Risk Managers of Hospital Employed Providers:

- **Credentialing** - Evaluate credentialing by proxy options to streamline and expedite the credentialing needs of remote providers.
- **Licensure** - Provider licensure should cover the states where patients will be assessed and treated and consider potential exceptions to licensure and licensure compacts.
- **Standard of Care** - Telemedicine does not inherently change the standard of care. However, the provider using telemedicine should consider whether the method of communication makes it more challenging to provide appropriate medical care.
- **Scope of Practice** - Comply with state delegation and supervision laws of non-physician providers that will be delivering telemedicine services.
- **Documentation** - Ensure all provider-patient interaction using telemedicine technology is appropriately captured in the patient's health record

- **Controlled Substances** - Comply with federal and state laws regarding prescribing controlled substances.
- **Financial** - Review reimbursement mechanisms to ensure payment.

Expanded CMS Reimbursement

Regarding reimbursement, Medicare has **temporarily expanded** its coverage of telehealth services. These services extend the current telehealth covered services, to give patients access from more places (including their homes), to a broader range of communication tools (including smartphones), to interact with a variety of providers (such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social worker). During this time, patients will be able to receive a specific set of services through telehealth, including evaluation and management visits (common office visits), mental health counseling, and preventive health screenings. This change helps ensure patients can visit their health care providers from their home, without having to go to a doctor's office or hospital, which reduces the risk of exposure to COVID-19.

Resources:

Telemedicine in the COVID-19 Era PODCAST: https://www.rmf.harvard.edu/Clinician-Resources/Podcast/2020/Telemedicine-in-the-COVID19-Era

The American Hospital Association (AHA) COVID-19 telehealth resources provide real-time updates to the telehealth rules and other helpful information. The link to these useful resources is: https://www.aha.org/issue-landing-page/2020-03-24-coronavirus-covid-19-telehealth-and-virtual-care

The Center for Connected Health Policy's (CCHP) National Telehealth Policy and Resource Center (NTRC-P). Lists 50-state laws, reimbursement regulations, policies, resources, and multiple links (as well as telephone contacts) for detailed resources and information. Located: https://www.cchpca.org/

Centers for Medicare and Medicaid Services

- https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak

Medicare temporary expansion of telehealth services (midway down page)

ASHRM Whitepaper examining telehealth risks utilizing the eight enterprise risk management (ERM) domains

ASHRM: Telemedicine Risk Management Considerations

For frequently asked questions on coverage during COVID-19, please see: MPIE COVID-19 FAQs on Coverage and Resources.

For additional COVID 19 resources, please see the MPIE Website: www.mpie.org

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Web Resources

NCIHC: National Standards of Practice for Interpreters in Health Care
http://www.ncihc.org/mc/page.do?sitePageId=57768

Patient forms available in various languages link click here

Patient Education Handouts for All Specialties
http://www.modernmedicine.com/patienteducation

Legal Consent Requirements for Treatment of Minors
https://www.networkforphl.org/resources/minors-health-privacy-michigan/

Mandatory Reporter Requirements
https://chanceatchildhood.msu.edu/

List of Error Prone Abbreviations, Symbols & Dose Designations
http://www.ismp.org/Tools/errorproneabbreviations.pdf

National Practitoner Data Bank Guidebook
https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp

HIPAA Resource
http://www.hhs.gov/ocr/hipaa/

Michigan Academy of Physician Asistants
https://www.michiganpa.org/

Pre-Employment Inquiry Guide: Questions You Can and Cannot Ask in Interviews
https://hr.msu.edu/policies-procedures/student-handbook/PreEmploymentGuide.html

MPIE Notice of Potential Claim Report Form click here

Litiagation Stress Management Services Brochure

Please click here to view the Litigation Stress Management Services Brochure.

SBAR Tool

Please click here to view the SBAR Tool.

Sample Office Brochure

Please click here to view sample medical & healthcare brochure templates.

Sample Forms

Sample Informed Consent Form

Please click here to view the sample informed consent form.

Sample Informed Refusal Form

Patient Name: _____ Date of Birth: _____

My physician, _____, has recommended the following treatment.
_____
_____

This treatment has been recommended to me the purpose of: _____
_____

My physician explained to me that the potentional benefits of this treatment include: _____
_____
and the risks include, but are not limited to: _____
_____
_____

Depsite my physician's recommendation, I have refused to consent to this medical treatment.

By signing this document, I understand that there are potentional risks, complications, and side effects involved in refusing this medical treatement. I understand that these potential risk, complications, and side effects could result in additional medical or surgical treatment or procedures, prolonged hospitalizations; or even permanent disability, severe injuries, or death.

Date: _____ Time: _____
Patient Signature: _____

___ The patient has read this form or had it read to him or her.
___ The patient states that he or she understands this information.
___ The patient has no further questions.

Date: _____ Time: _____
Witness Signature: _____

Sample Delegation of Authority of Minor

AUTHORIZATION FOR TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

This will authorize _____ and other staff under his/her supervision to provide medical care, including examination, treatment, x-ray examination, laboratory tests, local anesthetics, and medical diagnosis to _____ _____, a minior (DOB: _____).

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization in order to avoid delay in providing such treatment as is deemed necessaru by the aforementioned doctor(s).

This authorization to treat will remain in effect until _____, 20___, unless revoked sooner in writing. ***(Not to exceed 6 months)***

_____

Date

_____

Signature of Biological Parent(s)/Legal Guaridan/Legal Custodian

☐ This form authorizes said minor to present for routine minor care and treatment (such as allergy shots) unaccompanied bu an aduit. Minor must be 14 years of age or older and the practitioner has the option to choose not to treat the minor without authorized adult present.

☐ This form authorizes said minor to present for minor care and treatment accompanied by an adult other than his/her parent or legal guardian.
Please indicate those persons authorized to accompany this minor and their relationship to the minor.

_____

_____

☐ ***COPY TO PARENT OR LEGAL GUARDIAN*** (This form must be either notarized or signed by a witness)

Resource: Michigan Laws Related to Right of a Minor to Obtain Health Care without Consent or Knowledge of Parents

Sample Telephone Triage/Decision Guide

A number of malpractice claims involve the allegation that patient requests or symptoms are responded to in an inappropriate and untimely manner. The decision grid below can aid your office staff in deciding what information to relay to the physician and the relative importance of circumstances. It should be individualized to your specialty and practice situations.

Situation	**Patient to Emergency Room STAT!**	**Refer to Doctor STAT!**	**Advise: Doctor will call ASAP**	**Chart note, Leave with Doctor**	**Take Message, Leave with Doctor**
Telephone call re: patient conditions					
Chest Pains (severe)					
Difficulty Breathing					
Disoriented or Confused					
Possible Suicide					
Bleeding Heavily					
Severe Pain					
Reaction to Medication					
Poisoning/Overdose					
Vomiting					
Fever >102					
Suspected Fracture					
Pt. in Emergency Room					
Pt. Admitted to Hospital					
Hospital needs orders					
Patient Requests:					
Medical Condition/Diagnosis					
Test Results					
Medication Change					
Rx Refills					
Copies of Records					records clerk
Cancellation of Appointment				records reason	
App, delay >72 hours by pt.				records reason	
Angry about care or the bill					
Explanation of the bill					billing clerk
Others/Requests for:					
Health/Life/Disability. Ins					records clerk
Attorneys					
MD/PA Spouse or Children					

Sample Authorization to Release Healthcare Information Template

Authorization for [Name of Practice/Health Care Facility] to Use or Disclose My Health Care Information

Patient name: _____ Date of Birth: _____

Previous name:_____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All health care information in my medical record

☐ Health care information in my medical record relating to the following treatment to condition: _____

☐ Health care information in my medical record for the date(s): _____

☐ Other (e.g., x-rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus) or sexually transmitted diseases
☐ Psychiatric disorders/mental health or drug and/or alcohol use

You may disclose this health care information to:
Name (or title) and organization or class of persons: _____
Address, City, State, ZIP: _____

Reasons(s) for this authorization (check all that apply) (optional):
☐ at my request - check only if [practice/facility] requests the authorization for marketing purposes
☐ other (specify) - check only if [practice/facility] will be paid or get something for value for
☐ _____ Providing health information for marketing purposes

This authorization ends:
☐ on (date): or when the following event occurs _____
☐ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes for other than payment)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by [name of practice or health care facility] based upon this authorization. I may be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the [practice/health care facility].

  or

- Write a letter to the [practice/health care facility].

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws my no longer protect it.

_____

Parent or legal authorized individual signature

_____

Date

_____

Time

_____

Printed Name, if signed on behalf of the patient

_____

Relationship (parent, legal guardian, personal representative)

Sample Signature Log

This log should be updated to show the current signature and initials of each physician/ employee entries into patient records. This log must be kept in the practice administrative files.

Physician/Employee			**Employment Dates**
______________________	______________	__________	**FROM**______ **TO**______
FULL NAME, TITLE (PLEASE PRINT)	**SIGNATURE**	**INITIALS**	
______________________	______________	__________	**FROM**______ **TO**______
FULL NAME, TITLE (PLEASE PRINT)	**SIGNATURE**	**INITIALS**	
______________________	______________	__________	**FROM**______ **TO**______
FULL NAME, TITLE (PLEASE PRINT)	**SIGNATURE**	**INITIALS**	
______________________	______________	__________	**FROM**______ **TO**______
FULL NAME, TITLE (PLEASE PRINT)	**SIGNATURE**	**INITIALS**	
______________________	______________	__________	**FROM**______ **TO**______
FULL NAME, TITLE (PLEASE PRINT)	**SIGNATURE**	**INITIALS**	

Sample Medical Practice Survey Template

You may download this Medical Practice Survey Template off of the Microsoft website for free. https://templates.office.com/

Office LOGO

[Healthcare facility name]
[Street Address]
[City, State, Zip Code]
[Phone]

How Are We Doing?

Please take a few minutes to fill out this survey on thr timeliness and quality of the service you received today.
[Healthcare facility] welcomes your feedback and your answers will be kept confidential. Thank you for your participation.

General Patient Information

In general, what is the quality of your health?
__ Outstanding
__ Good
__ Some chronic issues
__ Poor

How would you rate your concern for your privacy:

__ Outstanding
__ Good
__ Needs Improvement
__ Poor

Sample Appointment Reminder Post Card

Office Name
Address
Phone number

Patient Name: _____

Appointment Date: _____

Time: _____

Provider: _____

If you are unable to keep your appointment, kindly give us 24 hours notice.

Sample Letter to Patient Who Fails to Keep Appointment

[Date]

Dear _____,

On_____, you failed to keep your appointment at my office. In my opinion, your condition requires continued
medical treatment. If you so desire, you may telephone me for another appointment, but if you prefer to have another physician attend you, I suggest that you arrange to do so without delay. You may be assured that, at your request, I am entirely willing to make available my knowledge of your case to the physician of your choice.

I trust that you will understand that my purpose in writing this letter is out of concern for your health and well-being.

If I do not hear from you by _____ regarding another
appointment with me, I will have no choice by to terminate our
physician-patient relationship.(Do so by sending second letter, if no response.)

Very truly yours,

cc: Medical record

Sample Policy on Handling Patient Concerns

Policy: Patient Concerns
Approved by: **Date approved:**
Supersedes date:

POLICY
Patients are encouraged to communicate any concerns they may have regarding their medical care.

PURPOSE
1. To promptly investigate patient concerns and resolve them.
2. To improve processes in delivery of medical care.
3. To enhance physician, staff and patient relationships.

PROCEDURE
1. A staff person is designated to serve as a patient representative or advocate.
2. During initial clinic visit, information is provided to patients about the process of communicating their concerns.
3. Patients are encouraged to provide feedback about problems they encounter when receiving medical care.
4. Handling patient concerns includes:
   - Listening to the patient without interruption or defensiveness.
   - Communicating regret regarding the patient's disappointment and appreciation of the patient's willingness to speak up.
   - Expressing empathy to patient.
   - Asking questions to clarify the patient's concern.
   - Finding out what the patient really wants.
   - Explaining to patient what can and cannot be done.
   - Discussing alternatives for corrective action to resolve concern.
   - Taking corrective action as soon as possible, if necessary.
   - Following up with patient after corrective action is implemented to ensure the patient's concern has been resolved.
   - Referring patient concerns to someone with higher authority or to patient representative or advocate, as necessary.
5. Documentation of patient's concerns includes:
   - Patient's name, telephone number and home address.
   - Facts related to patient's concern.
   - Patient's perception of problem.
   - Response of physicians or staff to patient's concern.
   - Options or suggestions given for resolving patient's concern.

- Actions physicians or staff agreed to take to resolve patient's concern.
- Name, position, telephone number and address of individual the patient can contact with questions or request a report on outcome of patient concern.

6. Patient concerns are summarized and analyzed, without patient identifiers (to help prevent discoverability of this information), to determine trends that can be incorporated into quality improvement activities.
7. Summarized patient concern results are analyzed, without patient identifiers (to help prevent discoverability of this information), to determine trends that can be incorporated into quality improvement activities.
8. Physicians and staff are educated about handling patient concerns.
9. Patient perceptions about delivery of medical care are monitored on an ongoing basis for problems that require corrective action and re-evaluation.

Sample Patient Termination Letter

[Date]

[Patient Name and Address]

Dear [Patient]:

This letter is to inform you that I will no longer be your physician and will stop providing medical care to you effective _____ (30 days from date of letter). The reason(s) for this decision is/are _____.

I will continue to provide routine and emergency medical care to you for 30 days while you seek another physician.

You can find a new physician by consulting the local physician referral service, your county medical society, or through yellow pages advertising.

I will forward a copy of your medical records to you or to your new physician upon receiving your signed, written request (see enclosed authorization form).

Sincerely,

Dr. Smith

cc: Patient File

Please click here to view the sample letter for discontinuing patients regarding masks

Sample Closing Your Practice Letters

SAMPLE LETTER TO PATIENTS ANNOUNCING RETIREMENT

Dear Patient:

After years of serving, you, and other patients, I have decided to retire from active medical practice. Accordingly, I will close my office permanently on _____. Between now and then, I will be happy to forward a copy of your records to a physician of your choice.

I am enclosing two copies of an authorization for the release of your records. Please complete the authorization and return one copy to me; the other copy is for you. If you need help in selecting a new physician, you may contact your health plan for assistance.

I extend to you my best wishes for your health and happiness. Sincerely,

John Doe, MD

Enclosure: Authorization to release records

SUGGESTED LETTER TO PATIENTS IF PRACTICE IS SOLD

Dear Patient:

As of _____, I will retire and transfer my practice to Dr. _____. She/he will be the custodian of the medical records of all of my former patients and would be pleased to continue your medical treatment if you choose. Of course, you have the right to choose any physician you wish. If you would like your records transferred to another physician, please indicate that doctor's name on the enclosed authorization, sign the authorization and return one copy to this office.

[Recommended: Include a brief paragraph summarizing the qualifications of the physician purchasing the practice.]

I have enjoyed the privilege of being your physician and thank you for the opportunity. If you have any questions, please call my office.

Sincerely,

John Doe, MD

Enclosure: Authorization to transfer medical records

Sample Letter: Physician Discontinuing Practice

Date

Dear Patients:

It is with mixed emotions that I am announcing my retirement from active practice, effective (date). It has been a great pleasure providing for your healthcare needs over the years, and it is not easy for me to give it up.

As of (date), Dr. Robert Smith will be taking over my practice. I am pleased that you have the opportunity to have him as your physician. Dr. Smith is a well-trained graduate of State University Medical School. He served his internship at Capital Memorial Hospital in Capital City and completed his residency at Jefferson University. I am glad to have left my patients in his capable hands. Of course, you may seek medical care from another doctor if you like. If you choose to do so, I recommend looking for a new physician as soon as possible. Ms. Carla Johnson at the Capital County Medical Society can help you begin your search by giving you the names of doctors in the area who are accepting new patients.

Your medical records are confidential, and a copy can be transferred to another doctor or released to you or another person you designate only with your permission. If you plan to continue with this office, you can sign an authorization form to release your files to Dr. Smith on your next visit. If you choose to see a different physician, please sign the enclosed authorization form, and return it to my office as soon as possible so we may transfer your records to your new doctor. Until then, your records will remain on file at my former office.

I have greatly valued our relationship and thank you for your loyalty and friendship over the years. Best wishes for your future health.

Sincerely,

Jane X. Doe, MD

Retirement or Sale of Practice Checklist

Notifications (60 to 90 days prior to closing)

Staff

- ❑ Notify employees of the practice closure.

Patients

- ❑ Prepare and send notification to patients listing the closing date and reason for closing. An authorization for the release of medical records should be sent with the letter.
- ❑ A dated copy of the notification letter should be saved in the patient's medical record.

The Public

- ❑ Ensure that signs regarding the closing of the practice have been posted within the office (reception area and treatment rooms).
- ❑ The practice website should include the date the practice is closing and the contact information for the medical records custodian.

Professional Associations

- ❑ Notify your state medical board, licensing board, credentialing organizations, professional memberships, etc.

Drug Enforcement Agency (DEA)

- ❑ Notify the DEA in writing and enclose DEA Controlled Substance Certificate and controlled substance order forms (cross out and write "void" on forms before sending).
- ❑ If changing the office address, send a letter to DEA six weeks in advance, notifying the agency of the change, along with old and new addresses.

Health Insurance Companies

- ❑ Send notification of retirement or a change of practice address to Medicare and Medicaid. Include the effective date of the retirement or address change.

Hospitals

- ❑ Notify the hospitals where you have privileges of your intention to close your practice.

Ancillary Services

- ❑ Contact ancillary services such as labs, MRI facilities, etc. that you refer patients to.

Suppliers/Service Contracts

- ❑ Inform medical suppliers, office suppliers, collection agencies, laundry services, housekeeping services, hazardous waste disposal services, magazine subscriptions, etc.
- ❑ Request final statements from these vendors to close your accounts with them.
- ❑ If the physician has practiced under a name other than his or her own, he or she should have filed an assumed name certificate with the county clerk. The physician should contact the county clerk to deactivate this assumed name if he or she is closing the practice without a buyer or if someone else is assuming the practice under that name.

Other Physicians

- ❑ If the physician has been practicing in a partnership (or had an operating agreement like a partnership to share office space) and the partnership will continue after the physician's retirement or departure, then withdrawing from the partnership or otherwise transferring the partnership interest is necessary. The departing physician should consult a lawyer regarding this matter.

Facility/Utilities

- ❑ Notify all utility service providers of the day you wish to discontinue service.
- ❑ Evaluate the terms of the lease and give notice to the landlord as required or consider options to renegotiate if the lease is longer than the time the physician wishes to remain in practice.

Tasks (30 to 60 days prior to closing)

Patient Scheduling

- ❑ No new patients should be accepted once the closing date is announced.
- ❑ Start restricting nonemergent appointments as much as possible.
- ❑ Patients who need continual follow-up and care should be referred to another provider.

Accounts Receivable

- ❑ Process accounts receivable to collect the money that is owed to you.
- ❑ Consider employing a collection agency or staff member to reconcile accounts after the practice has closed.

Insurance Policies

- ❑ Advise your professional liability insurance carrier of the physician's change in status. If the physician has a "claims made" policy, consider purchasing additional insurance to cover claims that may be filed after the coverage lapses. (This additional insurance is known as a "tail policy.") If the physician will be practicing part-time, insurance coverage may still be advisable.

Medical Records

- ❑ Make arrangements to store or transfer custody of medical records.
- ❑ Create a purchase contract with the buyer – the purchase agreement also should specify that the buyer/custodian will preserve the records for at least ten years and that the records may not be destroyed without your consent.

Clinic Documents & Equipment

- ❑ Investigate sources to sell or dispose of medical and office equipment.
- ❑ If the physician has operated X-ray and/or mammography equipment in the office, the physician holds a license from the Department of Health and must maintain a record of the transfer or disposal of such equipment.

Medications

- ❑ Inventory drugs and dispose of, sell, transfer, or donate according to federal and state requirements. Contact the Drug Enforcement Administration (DEA) for specifics.

Phone Service

- ❑ Consider including in the practice afterhours or lunch message along with the on call/emergency message that the practice will be closing and include the specific date. This message should be placed on the phone line 30-60 days before closing.

Mail Service

- ❑ Contact the U.S. Postal Service to coordinate mail forwarding details.[1]

Click here for a printable copy of the checklist.

Sample Employee Confidentiality Agreement Form

[Insert Name of Organization]
PLEDGE OF CONFIDENTIALITY

This is to certify that I, _____, an employee or volunteer of [Organization], understand that any information (written, verbal or other form) obtained during the performance of my duties must remain confidential. This includes all information about members, clients, families, employees and other associate organizations, as well as any other information otherwise marked or known to be confidential.

I understand that any unauthorized release or carelessness in the handling of this confidential information is considered a breach of the duty to maintain confidentiality.

I further understand that any breach of the duty to maintain confidentiality could be grounds for immediate dismissal and/or possible liability in any legal action arising from such breach.

_____
Signature of Employee/Volunteer

Sample Office Practice Self-Assessment

RISK MANAGEMENT SELF ASSESSMENT		
OFFICE NAME:		
QUESTIONS	Y	N
Does your office follow a patient complaint policy and procedure?		
Are patient satisfacion surveys periodically distributed to patients?		
Is there a policy/procedure in place to terminate non-complaint patients?		
Does someone in your office audit patient records to see if they meet consistent professional standards (labeled with patient identification, date and time, authenticated, legible, orderly, use of standard abbreviations, etc.)?		
Is there a policy/procedure for obtaining authorization for patients requesting their Protected Health Information (PHI)?		
Are staff members who access PHI formally trained on the practice's privacy policies/procedures?		
Are all staff clinical staff employment applicants' qualifications and experience reviewed, regardless of whether they have been credentialed by a hospital or other health care facility?		
Is the patient involved in informed consent/refusal discussions regarding their health care in a language and at a level that they can understand?		
Is a policy.procedure in place for tracking and promptly notifying patients of lab results		
Is there a comprhensive system in place to document patient telephone conversations and messages?		
Is there a good understanding of treatment and consent issues for minors?		
Is there a written policy to follow in the event of fraudulent use of the phyisicians DEA number (prescription fruad)?		
In the event of an unexpected outcome in a patient's care or treatment are the physicians aware of and enrolled in GAPP?		
Is there a good understanding by physicians and the office manager of the importance of prompt notification of potential claims to MPIE?		
Is there a clear understanding regarding the liability potential surrounding supervision requirements for mid-level providers?		
Are all potential new hire candidates subject to a background check?		
Does the practice retain medical records for the MPIE recommended length of time?		
Is there a response plan in the event of a disaster or violent patient?		
In the event of a HIPAA breach, is there a notification plan in place?		

Sample Discharge Form

Discharge Instructions
Diagnosis: _____
Procedure: _____
☐ *Post (procedure) instructions*

Account Number
MRN
Patient Name
DOB
Physician Name
Date of Service
Phone Number

SELECT/INDICATE INSTRUCTIONS THAT APPLY TO YOUR PATIENT

Diet
☐ _____
☐ As given by Diabetic Education

Activity
☐ _____

(Medication) Name/Dose	Time/Frequency	Prescription Given	Purpose

☐ **Schedule a follow up visit in:** _____	☐ **Schedule follow-up (lab, diagnosis test)** _____
Special Instructions _____	**Patient Education** _____ ☐ Pain Scale 1 2 3 4 5 6 7 8 9 10 ☐ Preferred method of learning ☐ Barriers to learning ☐ Interpreter present (name)

Follow-up Visit Date: _____ Time: _____ **Follow-up Diagnostic Test** Date: _____ Time: _____	**Office Hours (Monday-Friday) 8:30am - 4:30pm** **Physician Phone # (24 hour/7days) 616-555-9999**	*I understand the above information and, at this time my questions have been answered.* Date: _____ Time: _____ _____ Patient/Responsible person signature *This information has been verbally reviewed with the patient or responsible person.* Discharge Instructions given to: ☐ Patient ☐ Other _____ Date: _____ Time: _____ Provider Signature_____

Annual Review Discussion Topics

In the course of this annual review, we are also interested in your opinions concerning your practice and the clinic as a whole.

The following is an outline of possible areas to discuss. Certainly any issue is up for discussion.

by Dr. _____

Medical Director/President

Patient Care

1. In what areas could patient care be improved in your practice?
2. In what areas could patient can be improved within the clinic?
3. Could the resources (equipment and staff) be improved? If so, how?
4. Could ancillary service (lab and x-ray) be improved? If so, how?
5. Have you experienced any difficulties in accessing patients' medical records?
6. Are there problems with your partners or the office staff?
7. What changes would you like to see in your practice?

Administration

1. Is administration doing a good job of communicating with physicians?
2. What are the strengths and weaknesses of the physician and non-physician leadership?
3. Is there anything about the operation of the clinic you would like changed?

Peer Review

A summary of comments received from your peers.

Education/Community Involvement

1. Is there an adequate opportunity for educational advancement?
2. Are you having a problem meeting the CME requirements?
3. What community activities are you involved in?

Product/Income

A review of your production and how it compared to your peers

1. Does the clinic provide the resources to maintain an adequate production level?
2. Are you satisfied with the clinic's production incentives? How should they be changed?

Personal Items

1. Are you experiencing any problems that make it difficult to do your job?
2. How do you feel about the practice and the level of your energy, stress, satisfaction, etc?
3. Are there any family problems related to your work or schedule?
4. Are there any other items you would like to discuss?

Physician Evaluation Form

In order to provide a high and consistent level of care, the clinic reviews all members of the office staff and physicians on an annual basis.

Through documentation of the review process, we believe we can do a better job of rewarding outstanding practice and addressing areas that can be improved.

Please rate Dr. _____ in the following areas according to the scale. Please a mark at the appropriate place along the lines below to indicate the strength of your opinion in either direction.

1. Clinical Judgment

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

2. Technical Skills

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

3. Communication Skills

With M.D.. Staff

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

With Referring Physicians

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

With Office Staff

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

With Patients

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

4. Dependable and Organized

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

5. Response to Consultations and Call Schedule

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

6. Relationships with Hospital Staff

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

7. Practice Efficiency

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

8. Professional Image

0-(Unsatisfactory) 50-(Neither Good or Bad) 100-(Outstanding)

Summary Comments

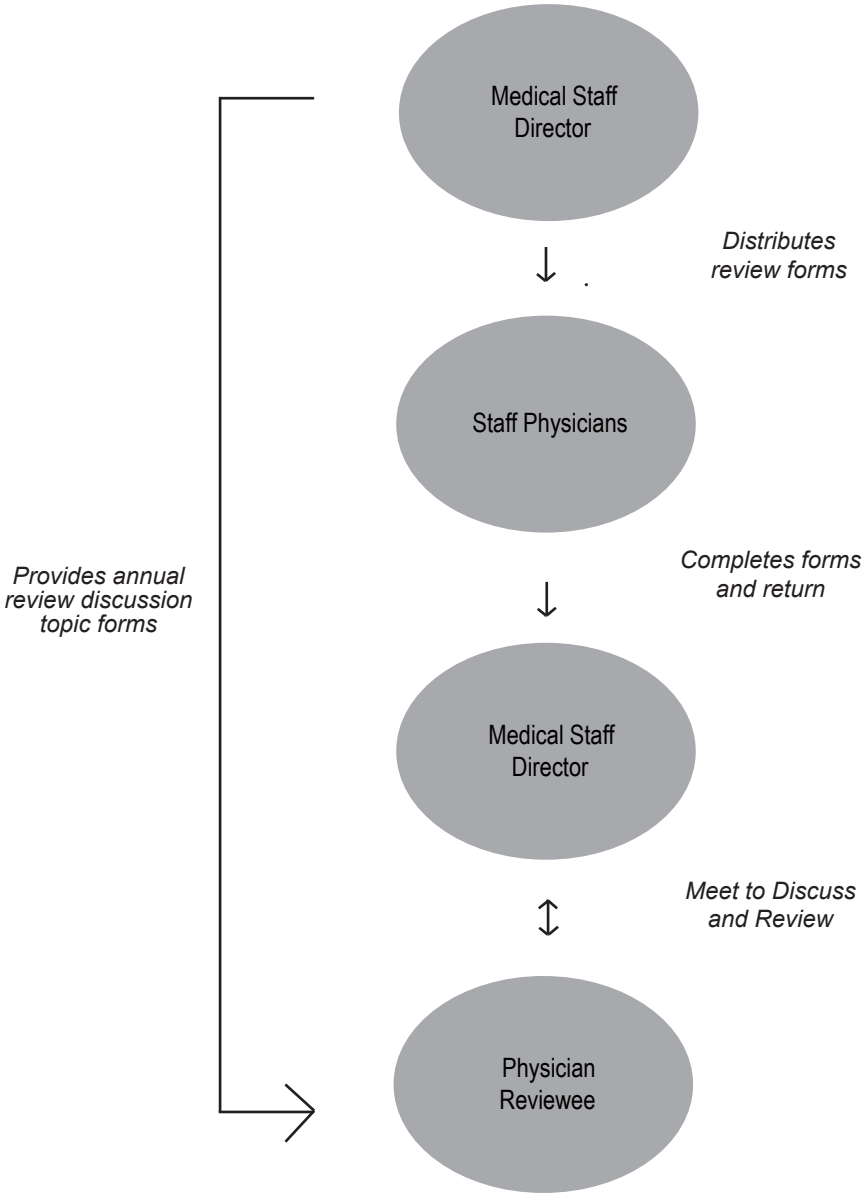
We would appreciate comments on all evaluations, and especially need them for any ratings below 50.

Name: (optional) _____

Date: _____ Year: _____

Please forward this form confidentiality to Dr._____ as soon as possible.

Annual Physician Review Process Map



Sample Policy: Incident Reporting for Ambulatory Care

POLICY

Incidents are reported as soon as possible through the incident reporting system.

PURPOSE

1. To provide timely intervention for patients injured in incidents.
2. To investigate incidents immediately.
3. To provide factual, timely and complete documentation of incidents.
4. To evaluate deviations from the standard of care, policies and procedures.
5. To collect data for identifying trends in frequency and severity of adverse events.
6. To determine corrective measures necessary to prevent recurrence of incidents.
7. To provide a means of refreshing the memory of those having direct knowledge of incident.
8. To notify risk manager of a possible professional liability claim.

PROCEDURE

1. An incident is defined as any:
   - Event that is not consistent with normal or usual operation of clinic.
   - Injury, potential injury and/or property damage.
2. Incident reports are nonjudgmental, factual reports of problems that exclude hearsay, opinions or assumptions.
3. Incident reports are labeled with the word “confidential” in a conspicuous place.
4. Reportable incidents include:
   - Adverse outcomes from treatment or procedure.
   - Falls.
   - Accidental burns.
   - Nerve damage.
   - Mistaken identity of patient.
   - Clinic acquired infections.
   - Medication errors.
   - Severe medication reactions.
   - Unexpected death.
   - Equipment malfunction.
   - Patient dissatisfaction.
   - Serious threats of lawsuits or complaints by patient or family.
   - Patient elopements.
   - Poisoning occurring within clinic.
   - External disasters (e.g., snow emergency, chemical spill/exposure, water supply

contamination, flood) that affect clinic operations.
    - Unscheduled termination of any services vital to clinic operations (e.g., termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control).
5. Incidents are:
    - Reported immediately in person or by telephone to attending physician, employee's manager and risk manager.
    - Communicated by the attending physician to patient and family, using carefully chosen words to objectively present facts and to express concern and compassion.
6. The risk manager handles incidents in which patients have been seriously injured or in which a clear liability situation exists, as follows:
    - Opens a case file.
    - Records personal patient information (i.e., name, age, address, family members, occupation and health insurance coverage).
    - Documents patient's current and underlying medical condition and reason for clinic visit.
    - Reads and copies pertinent portions of patient care record.
    - Lists the names of individuals involved in incident, their job titles, and how they can be contacted (e.g., telephone number or department).
    - Safeguards equipment, products or other evidence involved in incident.
    - Notifies billing department to hold bills temporarily.
    - Discusses incident with attending physician, including:
        - What happened during incident?
        - Patient prognosis.
        - Patient's and family's attitude about what happened.
        - What physician things would be appropriate with respect to billing the patient?
        - Who should contact patient and family?
        - Whether or not patient is entitled to any other compensation because of incident.
7. Patients who are injured and require immediate medical care are transferred to an acute care facility.
8. Incidents are immediately investigated to determine corrective action to be taken.
9. Admissions of fault or finger pointing to blame others is prohibited.
10. Equipment and products suspected of being involved in incident are promptly identified and secured to prevent use on other patients and to preserve potential evidence, including:
    - Patient care records.
    - Original X-rays.
    - Tissue specimens or samples/slides/photographs of specimens.
    - Fetal monitor strips.
    - Electrocardiogram strips.

- Videotapes.
- Photographs.
- Syringes.
- Purchase orders.
- Any implantable device that has malfunctioned and been removed (e.g., silicone breast implants)
- Any piece of equipment that causes injury.

11. Medical equipment and products suspected of being involved in incident are reported to manufacturer and supplier according to state and federal laws.
12. Medical equipment and products involved in incidents are tested by an outside facility.
13. The individual with the best knowledge of incident documents it on an incident report form immediately after incident is discovered.
14. All incident reports are reviewed by risk manager within 24 hours of receipt.
15. All incident reports are entered into a database for quality and risk management purposes.
16. Incident reports are analyzed to identify trends in frequency and severity of adverse events.
17. Incidents are documented in patient care records as follows:
    - Write and review chart entry before it is dictated or entered into patient care records.
    - Take time to think and choose words carefully.
    - Stick to facts.
    - Avoid any excuses that sound defensive, rationalizations, denials of wrongdoing, accusations and inflammatory comments.
    - Do not use “red flag” terms like “mistake,” “error” and “inadvertent.”
    - Tell the truth and avoid terms that misrepresent, exaggerate or understate facts.
    - Do not alter records or give the appearance of altered records.
    - Make no reference that an incident report was completed.
    - Never assign blame to yourself or to others.
    - Review the record for completeness of documentation of the incident and the response to any related medical emergencies.
18. Statements of witnesses are:
    - Handwritten.
    - Dated.
    - Time noted.
    - Signed by witnesses.
    - Attached to incident report form.
19. Comments from patients and visitors involved in incidents are documented, with quotation marks where applicable.
20. If a piece of equipment is involved in an incident, the following information is documented on incident report:

- Name of equipment.
- Manufacturer.
- Manufacturer's control number, if applicable.
- Clinic's control number.
- Facts that indicate malfunction if there is suspected malfunction of equipment.
- Other related information.

21. Peer review is conducted so care is evaluated at least quarterly and results are used for credentialing and medical quality review.
22. Incident reports are treated confidentially.
23. Only one copy of completed incident report is made and given to risk manager.
24. The risk manager sends one copy of completed incident report to professional liability insurance carrier as notice of claim or potential claim.
25. Completed incident reports are filed separately from patient care records in a secure file.
26. Incident reporting process is monitored on an ongoing basis for problems that require corrective action and re-evaluation.

Sample QI Policy for Large Physician Practices

Policy on Quality Improvement and Utilization Management Regarding Credentialing Provider

Background:

Concerns or complaints about a provider's performance can come from many sources including, but not limited to: patient calls, letters or satisfaction surveys, communications from health plans, inquiries from state or federal regulatory agencies, civil or criminal investigations or lawsuits, information reported by peers or coworkers to practice management, legal counsel, compliance office or chief medical officer, calls to the Group hotline, or issues discovered during the credentialing or recredentialing process or issues identified during other organizational quality improvement initiatives. It is important for a medical group such as Group to oversee the quality of its providers by having a single centralized process to collect, investigate and appropriately address in a timely manner any concerns involving the quality of service, professional competence or utilization management of a credentialed provider.

Policy Scope:

This policy applies to any issues or complaints about quality, professional competence or utilization management issues ("QI/UM Issue") involving a credentialed provider, including a physician, physician assistant, nurse practitioner, physical therapist and any other clinician credentialed by Group.

Procedure:

1. Any QI/UM Issue involving a credentialed provider should be forwarded to the Chief Medical Officer/Medical Group Lead Physician as soon as practical, by phone, fax or email.
2. The person reporting the QI/UM Issue should include his/her name, the name of the provider, a brief description of the issue and any investigation that has been performed and a telephone number where he or she can be reached.
3. The Chief Medical Officer/Medical Group Lead Physician will conduct further investigation to confirm whether a QI/UM Issue exists and determine the appropriate follow-up or remediation. To the extent possible, QI/UM Issues will be addressed in a peer review process in order to allow maximum candor while protecting any available privilege under state law. Conference with legal counsel may be required to ensure protection of investigation and remediation process.
4. The outcome of each investigation and any suggested or required remediation will be documented.
5. The Chief Medical Officer/Medical Group Lead Physician may refer certain QI/UM

Issues to other appropriate personnel, as necessary. For example, if a QI/UM Issue requires investigation or remediation on a billing rule, the CMO will refer such QI/UM Issue to the Chief Compliance Officer and/or coding expert.

6. For any QI/UM Issue that may result in suspension, termination or any other disciplinary action, the process outlined in the applicable Medical Group policy on provider disciplinary action must be followed.
7. Consistent with existing policy and physician employment agreements, the Medical Group Physicians, PC Board makes all decisions concerning physician disciplinary action including, but not limited to, suspension or termination.
8. Consistent with existing policy, the manager for all non-physician providers is responsible for making final decisions concerning disciplinary action, including suspension or termination.
9. All QI/UM Issues will be recorded in a confidential database with access limited to the Chief Medical Officer/Medical Group Lead Physician, Compliance Officer and General Counsel. As necessary, reports can be generated from this database. At a minimum, a quarterly report will be provided to the Group Physicians, PC Board regarding the status and number of any QI/UM Issues.

PC Board Resolutions

RESOLVED that Medical Group Physicians, PC adopt this Policy on Quality Improvement and Utilization Management, including the procedure that will be adhered to on a consistent basis for any Group-credentialed provider. Further, this Policy and Procedure will be implemented immediately and with the purpose of establishing a single centralized process to collect, investigate, and appropriately address in a timely manner any and all concerns involving the quality of service, professional competence, or utilization management of a credentialed provider.

Sample General Liability Contact Information Form

Name & Address of Facility:	
Practice Manager:	Phone #: Email:
Buidling Owner:	Phone #: Email:
Billing Manager:	Phone #: Email:
General Liability Insurer for Inside Suite:	Contact Name: Phone #: Email:
General Liability Insurer for Outside Suite:	Contact Name: Phone #: Email:

**Please be aware Michigan Professional Insurance Exchange (MPIE) may not be the insurer for incidents occurring on your premises this depending on location of incidents and/or lease arrangements. It is your responsibility to know who the correct insurer is for both inside and outside your office.*

MPIE General Liability Incident Report Form

Please click here to view the MPIE General Liability Incident Report Form.

Dept. 4152
PO Box 30516
Lansing, MI 48909-8016

www.mpie.org