MLMIC®

Risk Management Tips

for Today's Medical Practice

Volume II

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In the complex and busy world of healthcare delivery, physician practices may overlook basic office procedures that promote patient safety and reduce exposure to liability. This handbook identifies potential risks and provides recommendations to mitigate them. Each tip is designed to address a common issue in the office practice and provide practical guidance on how to employ best practices. These easy-to-implement recommendations are a guide for physicians, other healthcare providers, and staff. The implementation of these recommendations may assist in preventing adverse outcomes, improving patient care, and minimizing liability exposure in the office practice.

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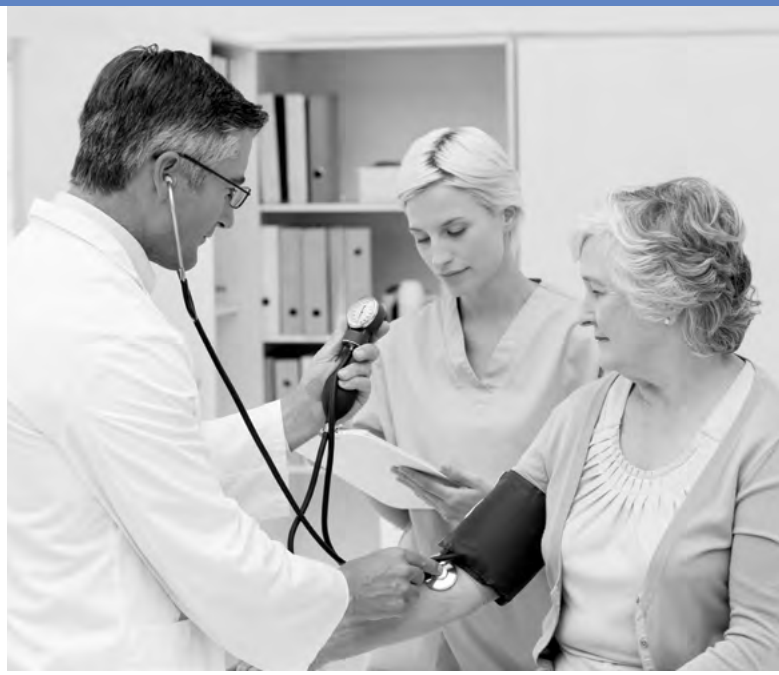


Tip #11: Using Chaperones During Physical Examinations

The Risk: Providers must recognize that, at any time, a patient may make a complaint to the Office of Professional Medical Conduct alleging that he or she was the victim of a physician's sexual misconduct. Having a chaperone present during intimate physical examinations may be beneficial to both the physician and the patient. First, it may provide reassurance to patients, demonstrating both respect for their concerns and an understanding of their vulnerability. Second, the use of chaperones can provide legal protection for the physician in the event of a misunderstanding or false accusation of sexual misconduct on the part of the patient.

Recommendations:

1. A provider should always use a chaperone when performing breast or pelvic examinations.
2. Consideration also should be given to the use of a chaperone for:
   - rectal and/or testicular examinations;
   - unusual situations where the physician is concerned that the patient, spouse, or family member may seem uncomfortable or apprehensive;
   - when a parent or spouse demands to be present; and
   - when a patient acts seductively or otherwise inappropriately.
3. The presence of a chaperone must always be documented in the patient's medical record.
   - The provider can simply document "chaperone in room for the entire exam" and the chaperone's initials.
   - Adding the name and title of the staff member who chaperoned the exam allows you to verify their presence at a later date, should the need arise.
4. A template indicating the use of a chaperone is available from Fager Amsler Keller & Schoppmann, LLP from which either a stamp for a paper record or a data field for an electronic health record (EHR) can be used in your office.
5. A chaperone should be provided even if the provider is the same gender as the patient.
6. Chaperones should be educated about patient privacy and confidentiality issues.
7. Unless specifically requested by the patient, family members should not be used as chaperones.
8. Respect for the patient's privacy can be further maintained by speaking to the patient privately before and/or after the examination.

Tip #12: Promoting Communication Between Referring and Consulting Physicians

The Risk: Lack of communication between providers may result in poor coordination of care. This may include a delay in diagnosis or treatment, the failure to order diagnostic testing or act upon abnormal test results, or the failure to prescribe appropriate medications. Clearly defining the roles and responsibilities of the referring and consulting physicians will promote safe and effective patient care.

Recommendations:

1. A tracking system should be in place to determine if the patient obtained the recommended consultation.
2. Referring physicians should develop a process for determining whether a report has been received from the consulting physician.
3. All consultation reports must be reviewed by the referring physician prior to being placed in, or scanned into, the patient's medical record. Paper copies should be initialed and dated.
4. If a patient has been non-compliant in obtaining the recommended consultation, follow-up is necessary. Document all attempts to contact the patient and any discussions with the patient, including reinforcement of the necessity and reason for the consultation.
5. If a report is not received in a timely manner, contact the consultant to determine if the patient has been seen and whether a report has been generated.
6. Consultants should routinely send reports to referring physicians in a timely manner. These reports should include the:
    - findings;
    - recommendations including interventions; and
    - delineation of provider responsibility for treatment and follow-up of test results.
7. The consultant should contact the referring physician when a patient fails to keep an appointment. The medical record should reflect the missed appointment, as well as notification of the referring physician.
8. All telephone conversations between referring and consulting physicians should be documented. Timely communication must occur when an urgent or emergent clinical finding is identified.

Tip #13: Handling Patients Complaints Properly

The Risk: Patient satisfaction is an integral part of providing healthcare, regardless of the clinical setting. Dissatisfaction with medical care may be a harbinger of medical malpractice litigation. When you receive a complaint about care, how you handle the situation may directly impact the potential for any future litigation. All physician office practices should have a policy or protocol in place to address patient complaints.

Recommendations:

1. One individual should be identified and consistently used as the primary person to address patient complaints. This is often the office manager.
2. All staff should know to whom complaints should be addressed, as well as what information constitutes a complaint that requires attention or intervention by that person. This should, at a minimum, include:
   - written or verbal complaints regarding medical care;
   - billing or payment issues that involve concerns about the clinical care; and
   - letters of complaint from third party payors, IPRO, NYS Department of Health, or other regulatory entities. We recommend that you retain personal counsel for assistance in formulating written responses to such agencies.
3. Effective communication skills are essential when addressing a patient complaint.
   - Express concern for the patient's condition and wellbeing.
   - Never be adversarial or defensive.
   - Be an active listener and ask questions when appropriate.
   - Avoid judgmental comments about patients and their families, or negative remarks about staff, physicians, or other providers.
   - Investigate complaints and follow up as indicated.
4. Conversations with patients should be documented in the medical record. It is appropriate to quote the patient when documenting their concerns.
5. Keep letters of response to complaints concise and simple. A copy of the written response should be kept in the patient's medical record.
6. When complaints involve clinical issues or are complex, physicians or other providers should be involved in addressing the situation.
7. Attorneys' requests for records may be an indication of a patient's unhappiness. The patient's medical record should be reviewed in conjunction with these requests in an effort to assess the potential for medical malpractice litigation.
8. Consider seeking guidance when presented with unusual or difficult situations. MLMIC staff is available to assist insureds with handling complaints, formulating responses, and determining potential exposure to claims of malpractice.
9. Never document any contact with MLMIC or your attorneys in the patient's medical record.

Tip #14: Managing Drug Seeking Patients

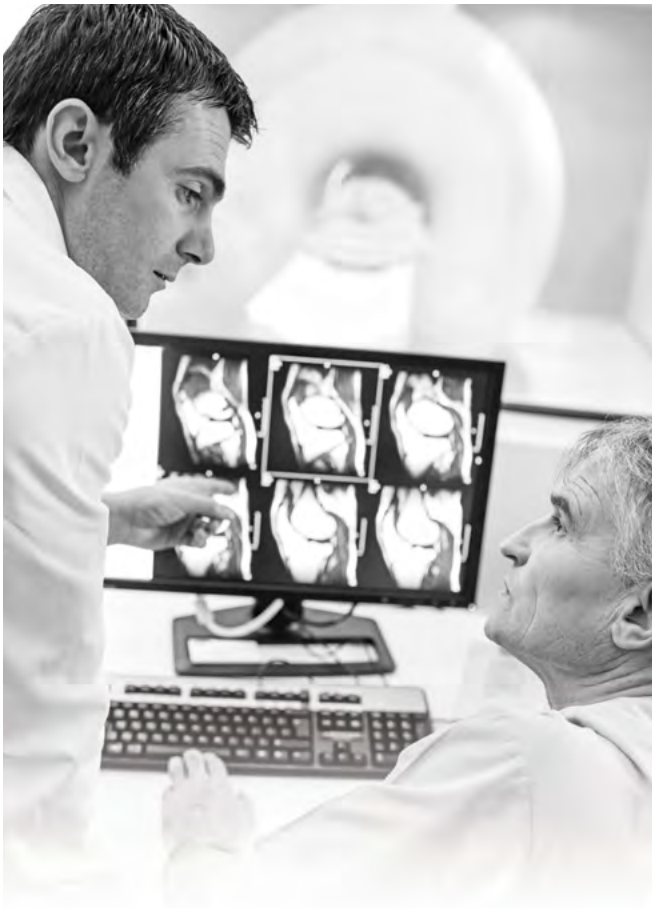
The Risk: Healthcare professionals share in the responsibility for minimizing prescription drug abuse and drug diversion. Physicians are tasked with differentiating patients in need of effective pain management from those who may be seeking drugs for inappropriate reasons. The following recommendations are intended to provide guidance for healthcare providers when confronted by drug seeking patients.

Recommendations:

1. Perform a complete review of the patient's pertinent history, and conduct a thorough medical evaluation. Address and document all objective signs and symptoms of pain.
2. Exercise concern when dealing with patients who are not interested in having a physical examination, are unwilling to authorize the release of prior medical records, or have no interest in a diagnosis or a referral, saying they want the prescription immediately.
3. Be cautious if a new patient has an unusual knowledge of controlled substances, or requests a specific controlled substance, and is unwilling to try any other medication.
4. Document a trial of non-narcotic medication and/or physical therapy before choosing to place the patient on a controlled substance.
5. If you are able to identify the true source of the patient's pain, document that and any positive test results in the medical record.
6. New York State physicians must consult the I-Stop registry prior to prescribing any Schedule II, III or IV controlled substances. To establish a Health Commerce System account to enable you to do so, access the website at https://hcsteamwork1.health.state.ny.us/pub/top.html.
7. Document the patient's informed consent for treatment of chronic pain with controlled substances. Have the patient sign a written pain management agreement (available from Fager Amsler Keller & Schoppmann, LLP) when prescribing controlled substances for chronic pain.
8. Specifically document drug treatment outcomes and the rationale for medication changes.
9. Assess whether further treatment for addiction or pain management is appropriate, and document this discussion with the patient. If necessary, refer the patient for consultation to a pain management clinic or to a rehabilitation facility.
10. Carefully monitor and protect Official New York State Prescription pads if you use them. Unless an exemption is applicable, prescriptions for controlled substances are to be electronically dispensed.
11. When electronically issuing or writing a prescription for controlled substances, write the quantity and the strength of drugs in both letters and numbers to prevent alteration.
12. Report patients who are reasonably believed to be habitual users or abusers of controlled substances to the New York State Bureau of Controlled Substances. This is required by New York State Public Health Law §3372.
13. Contact the law firm of Fager Amsler Keller & Schoppmann, LLP to discuss how to address a patient who you believe is selling/diverting narcotics, or altering, forging, or stealing prescription pads.

Tip #15: Communicating and Following-Up Critical Test Results

The Risk: The communication of test results is an important part of providing care and may involve various healthcare professionals. Test results may be overlooked, lost, scanned into the wrong record, etc. Abnormal test results requiring follow-up present an additional risk if they are not received, reviewed, or communicated to the patient. This may result in missed or delayed diagnoses, patient injuries, and subsequent claims of malpractice. If a physician orders a test, he or she is responsible for ensuring that the results have been received and reviewed. Physician practices should have policies and procedures in place for the management of test results.



Recommendations:

1. All ordered tests must be documented in the patient's medical record.
2. A process should be in place to confirm and document the receipt of test results. Many electronic health record systems allow practices to efficiently track pending laboratory/diagnostic studies.
3. All incoming laboratory reports and diagnostic tests must be reviewed and authenticated by the provider.
4. The provider must document communication of the test results to the patient. Any recommendations or interventions must also be documented.
5. Providers should have a system in place for the follow-up of pending laboratory/diagnostic test results for their patients who have been discharged from the hospital or emergency department. Receipt and review of these results should be documented in the patient's medical record. Communication of the results to the patient should also be documented.
6. It is important for physicians to clearly establish who is responsible for follow-up when tests are ordered for a patient by another specialist or consultant.
7. Patients should be advised of all test results, normal or abnormal. This communication should be documented in the medical record.

Tip #16: Promoting Adherence to a Medication Regimen

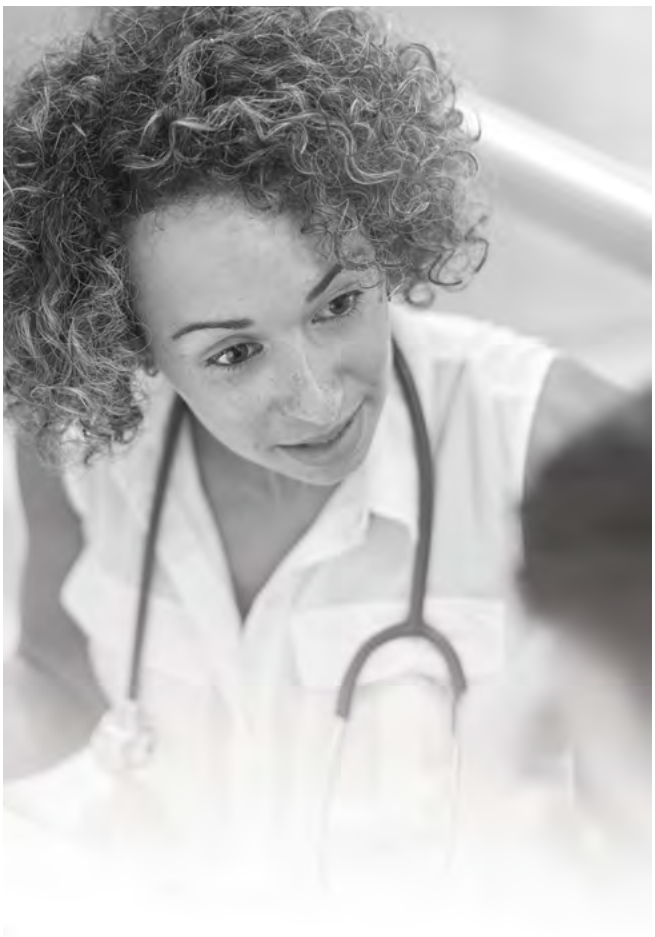
The Risk: Patient nonadherence to a prescribed medication regimen is a common problem that physicians in all specialties encounter. Some factors that may influence medication adherence include the complexity of the regimen, the age of the patient, and the cost of medications. Patients and/or caregivers should be advised of the importance of taking medications exactly as directed. Educating patients regarding the use of medications should include information about potential drug interactions, side effects, and other related problems that may warrant medical intervention.

Recommendations:

1. Prescribing providers should educate patients about each medication, including its name, appearance, purpose, and effect. This education should include any potential side effects and/or interactions associated with the medication regimen. It should also stress the importance of contacting a healthcare provider should any reactions, questions or concerns arise.
2. Query patients regarding any underlying issues with medication selection in order to resolve any concerns.
3. The importance of using only one pharmacy to obtain all medications should be emphasized to patients or their representatives.
4. Patients should also be advised to:
   - keep an accurate list of all medications including generic and brand names, over-the-counter medications, and herbal supplements, which includes dosages, dosing frequency, and the reasons for taking the medication;
   - maintain a complete list of medical providers and their contact information;
   - post the name and telephone number of their local pharmacy in a prominent location along with the name and phone number of their physician;
   - establish a daily routine when taking their medications; and
   - bring a list of all medications that they are taking to each and every appointment.
5. Make patients aware of the various medication adherence aids and devices available, such as dosing reminders, pill boxes, and refill reminder programs.
6. Provide useful written information in plain language that clearly explains how patients can correctly manage their medications.
7. Consider utilizing the “teach back method” when explaining medications to patients. First teach the information, then ask patients to repeat it back in their own words.
8. Physicians should help patients manage their medications, caution them to not share medications, and advise them to follow storage recommendations and dispose of old medications properly.

Tip #17: Communicating with Low Health Literacy Patients

The Risk: The lay public often has limited knowledge and understanding of medical terminology. A patient's ability to understand medical information may be compounded by stress, age, illness, and language or cultural barriers. Effective communication with patients may improve compliance with treatment regimens, enhance the informed consent process, and increase safe medication use. Physician office practices can improve the patient experience, and reduce potential liability exposure, by employing the following recommendations.



Recommendations:

1. Use lay terminology whenever possible. Define technical terms with simple language. Patient education materials should be written in plain language, avoiding the use of medical jargon.
2. Verbal instructions may be reinforced with visual aids and printed materials that are easy to read and include pictures, models, and illustrations. Consider using non-printed materials, such as videos and audio recordings, as indicated.
3. Offer to assist your patients when completing new patient information or any other practice documents. Provide this help in a confidential way, preferably in an area that is private and conducive to this type of information exchange. Encourage your patients to contact you with any further questions.
4. The use of interpreters may be indicated for patients who are not fluent in the English language.
5. At the end of the encounter, use open ended questions rather than yes/no questions to further assess patient understanding. Instead of asking "Do you have any questions?" try asking "What questions do you have for me?"
6. Providers and staff should be familiar with and utilize the principles of the "teach back method" when reviewing new medications or treatment plans with patients. First teach a concept, then ask patients to repeat back the information they just heard using their own words.
7. Patients and family members may be embarrassed by, or unaware of, their healthcare literacy deficits. An empathetic approach to understanding patient health literacy will enhance your physician-patient relationship.

Tip #18: Discontinuing the Physician–Patient Relationship Properly

The Risk: Once the physician-patient relationship is established, physicians have a legal and ethical obligation to provide patients with care. However, there may be circumstances when it is no longer appropriate to continue the physician-patient relationship. A physician may choose to discharge a patient for a variety of reasons such as noncompliance with treatment, failing to keep appointments, or inappropriate behavior. Properly discharging a patient from care can be a complex issue. In order to avoid allegations of abandonment, providers should consider establishing a formal process for discharge.

Recommendations:

1. The discharge of each patient must be determined by the physician on an individual basis and based on medical record documentation of patient noncompliance or disruption. We recommend that you contact Fager Amsler Keller & Schoppmann, LLP for specific advice.
2. A formal patient discharge should be made in writing. You must give the patient at least 30 days from the date of the letter to call you for an emergency in order to avoid charges of abandonment. This time period may be longer depending on the patient's condition and the availability of alternative care.
3. The three most common reasons why physicians discharge patients are:
   - nonpayment;
   - noncompliance with the physician's recommendations; and
   - disruptions in the physician-patient relationship.
4. The discharge is to be effective the date of the letter.
5. Refer the patient to the local county medical society, their health insurer, or a hospital referral source to obtain the names of other physicians.
6. Provide the patient with prescriptions for an adequate supply of medication or other treatment during the 30 day emergency period.
7. Use the USPS certificate of mailing procedure, not certified mail, to send the discharge letter so it can not be refused/unclaimed by the patient, and it can be forwarded if the patient has moved.
8. Discharge may not be an option in all situations. For example, discharge is not recommended if the patient:
   - is in need of urgent or emergent or continuous care without a gap;
   - is more than 24 weeks pregnant; or
   - has a disability protected by state and federal discrimination laws.

   In these or similar circumstances, the physician should discuss the patient's situation with counsel before moving forward with a plan to discharge from care.
9. Become knowledgeable about the requirements regarding any restrictions on discharge imposed by the third party payors with whom you participate.
10. Promptly send the patient's records to the patient's new physician upon receipt of a proper authorization.
11. Flag the office computer or other appointment system in use to avoid giving the patient a new appointment after discharge.
12. Document the problems that have led to the discharge in the patient's record.
13. Form letters and a memorandum on the discharge of patients are available from Fager Amsler Keller & Schoppmann, LLP.

Tip #19: Treating Patients with Whom You Have a Close Relationship

The Risk: Physicians are often asked by close friends, relatives, or colleagues for medical advice, treatment, or prescriptions both inside and outside of the office. At times, these individuals may be seen by you as a courtesy and/or at no charge. Although the American Medical Association advises physicians not to treat immediate family members except in cases of emergency or when no one else is available, this practice continues to occur.

Over the years, we have seen a number of lawsuits filed against physicians by close friends, colleagues, and even their own family members because of care provided by our insureds. The defense of these suits is frequently hampered by the fact that there are often sparse or entirely non-existent medical records for the patient. The failure to maintain a medical record for every patient is defined as professional medical misconduct by Education Law § 6530(32). Providing care under these circumstances may pose unique risks. Here are some recommendations about how to handle these situations.

Recommendations:

1. Always create a medical record for friends, relatives, and colleagues for whom you provide care of any kind.
2. All patient encounters must be documented in the medical record, including those that occur outside the medical office.
3. Take a complete medical history when seeing friends, relatives, or colleagues as patients. If indicated, this should include issues that may be uncomfortable to discuss, such as the use of psychotropic medications or sexual history.
4. A thorough medication history should be obtained from the patient to avoid potential drug interactions. Identify any contraindications when prescribing medication.
5. Perform a thorough physical examination. Sensitive portions of a physical examination should be deferred when pertinent to the patient's complaints. These may include breast, pelvic, or rectal examinations. A chaperone should be used for those portions of the examination.
6. Do not write prescriptions, especially for controlled substances, for individuals with whom you do not have an established professional relationship. Always document the reasons for prescribing medications along with the dose. If narcotics are prescribed, consult the Prescription Monitoring Program (I-STOP) registry and document that in the medical record.
7. If a surgical procedure is to be performed:
   - a signed informed consent form must be obtained and placed in the medical record; and
   - the medical record must contain documentation that the informed consent conversation with the patient has occurred and that the patient consented to the procedure.

Tip #20: Reducing the Risk of the "Copy and Paste" Function in Electronic Health Records

The Risk: The "copy and paste" function of electronic health record systems (EHRs) allows users to easily duplicate information such as text, images, and other data within or between documents. While this function offers convenience and efficiency to healthcare providers, it also poses unique liability risks when the information copied and pasted is either inaccurate or outdated. Further, using this feature may result in redundancy within the new entry and create difficulty in identifying current information.

Recommendations:

1. Develop a comprehensive policy and procedure for the appropriate use of the copy and paste function. The policy should include a process to monitor and audit both the staffs' and providers' use of this function.
2. Educate all EHR users about:
   - the importance of verifying that the copied and pasted information is correct and accurately describes the patient's current condition;
   - the risks to patient safety in the inappropriate use of this function; and
   - the importance of adhering to all regulatory, legal, and compliance guidelines.
3. Determine what portions of the record should be copied and pasted. At a minimum, the healthcare provider's signature(s) should not be copied and pasted.
4. Confirm that the source of information which has been copied and pasted can be readily identified and is available for review in the future.
5. Confirm that the history of the present illness is based upon the patient's description during that visit.
6. Use the medical, social, or family history from a previous note only after it has been reviewed with the patient to confirm it is relevant to the current appointment.
7. Verify that the diagnoses in your assessment are only those addressed at that visit. Although some EHRs allow the copying of all diagnoses in the problem list, some may either have already been resolved or they are not the reason for this particular encounter.
8. Contact your EHR vendor as necessary to help you and your staff comply with established policies. This may include the vendor making modifications which disable the copy and paste function in designated fields, and assisting in performing audits of the use of the copy and paste function by staff and providers.

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For additional Tips and risk management resources please visit **MLMIC.com**

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