MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

Risk Management Tips

for Healthcare Providers & Facilities

Medical Edition

In the healthcare industry, every detail matters.

Small things, when missed, can lead to big problems. It's important for healthcare providers and facilities to ensure procedures are followed that promote patient safety and reduce exposure to medical professional liability. MLMIC Insurance Company created this handbook to help identify potential problem areas and find recommendations for improving them.

From office policies and patient communications to technology use and more, these risk management tips are designed to offer guidance on the most effective and efficient methods for handling a wide range of medical practice issues. Implementing these recommendations may assist in preventing adverse outcomes, improving patient care, and minimizing liability exposure in the office practice.

Contents

1

Office Policy and Procedure

Maintaining Patient Confidentiality

The Risk

Patient confidentiality breaches pose a significant risk in the healthcare setting. The Health Insurance Portability and Accountability Act (HIPAA) and New York State laws govern your obligation to maintain the confidentiality of protected health information (PHI). Staff and providers must be aware that routine office practices, including telephone contact, verbal discussions, and computer use, inherently carry the risk of patient confidentiality breaches.

Recommendations

1. Staff should be educated, at a minimum annually, about the HIPAA and patient confidentiality. This should be documented and maintained in their personnel files.
2. Confidentiality agreements should be signed by all staff members.
3. Staff conversations regarding patient care should not be audible to patients and visitors in the waiting area.
4. Staff should be advised to never discuss patients outside the office, including the use of social media.
5. The flow of patients through the office should be assessed to determine how best to maintain the privacy of PHI.
6. Computer screens should not be visible to patients or visitors.
7. Computers in exam rooms should not be left on or active when staff or providers are not present.
8. Any electronic device that is used for the transmission of PHI must be encrypted and have regular software updates installed.
9. The practice can leave messages on patient answering machines (e.g., regarding appointments) only if contained in its Notice of Privacy Practices. Patients must be offered the option to opt out.
10. Business Associate Agreements must be obtained and maintained for all vendors that have access to PHI.

Maintaining Patient Confidentiality

Patient confidentiality breaches pose a significant risk in the healthcare setting. The Health Insurance Portability and Accountability Act (HIPAA) and New York State laws govern your obligation to maintain the confidentiality of protected health information (PHI). Staff and providers must be aware that routine office practices, including telephone contact, verbal discussions, and computer use, inherently carry the risk of patient confidentiality breaches.

	YES	NO
1. Staff have been educated, at a minimum annually, regarding HIPAA and patient confidentiality. Attendance is documented and maintained in their personnel files.	☐	☐
2. Confidentiality agreements have been signed by all staff members.	☐	☐
3. Staff conversations regarding patient care are not audible to patients and visitors in the waiting area.	☐	☐
4. Staff have been advised to never discuss patients outside the office, including on social media platforms.	☐	☐
5. The flow of patients through the office has been assessed to determine how best to maintain the privacy of PHI.	☐	☐
6. Computer screens are not visible to patients or visitors.	☐	☐
7. Computers in exam rooms are not left on or active when staff or providers are not present.	☐	☐
8. Any electronic device that is used for the transmission of PHI is encrypted and has regular software updates installed.	☐	☐
9. The practice can leave messages on patient answering machines (e.g., regarding appointments) only if contained in its Notice of Privacy Practices. Patients are offered the option to opt out.	☐	☐
10. Business Associate Agreements are obtained and maintained for all vendors that have access to PHI.	☐	☐

Tracking Test Results

The Risk

The receipt and review of test results are important aspects of patient care and safety in physician practices. Tests may not be completed, or results may be lost, overlooked, or not received, leading to a potential delay in diagnosis and subsequent liability exposure. Follow-up procedures should be an integral part of your practice and can help ensure that patients obtain the necessary testing as ordered and that results are received, reviewed, and properly addressed.

Recommendations

1. Inform patients about the indications for the test(s), and document these conversations in their medical records.
2. Implement a follow-up system in your practice to ensure that patients have undergone the recommended test(s) and that the results are returned to the office.
3. The follow-up system should allow you to track the following information: patient name, test order date, and the date the results were received.
4. The medical record should indicate the date of the provider review.
5. It is the provider's responsibility to notify patients of significant test results. This should be documented in their medical records.
6. Your process should include follow-up when patients have not undergone the recommended test(s). This may include telephone and/or electronic communication. All attempts to reach the patient should be documented in the medical record.
7. A follow-up mechanism that utilizes the same process should also be in place to track consultations.

Tracking Test Results

The receipt and review of test results are important aspects of patient care and safety in physician practices. Tests may not be completed, or results may be lost, overlooked, or not received, leading to a potential delay in diagnosis and subsequent liability exposure. Follow-up procedures should be an integral part of your practice and can help ensure that patients obtain the necessary testing as ordered and that results are received, reviewed, and properly addressed.

	YES	NO
1. Patients are informed about the indications for a test(s), and these conversations are documented in the medical records.	☐	☐
2. A follow-up system has been implemented in the practice to ensure patients have undergone the recommended test(s) and the results have been received by the office.	☐	☐
3. The follow-up system allows us to track the following information: patient name, name of test(s), test order date(s), and the date(s) the results were received.	☐	☐
4. The medical record indicates the date the provider reviewed each test result.	☐	☐
5. Providers are responsible for notifying patients of significant test results. This is documented in the patient's medical record.	☐	☐
6. Follow-up is performed when patients have not undergone the recommended test(s). This may include by telephone, by mail, and/or electronic communication through the patient portal. All attempts to reach the patient are documented in the medical record.	☐	☐
7. A follow-up mechanism that utilizes the same process is also in place to track consultations.	☐	☐

Follow-Up of Missed or Cancelled Appointments

The Risk

A missed or cancelled appointment and the failure to follow up with or contact the patient may result in a serious delay in diagnosis or treatment. A well-defined process that includes provider notification and follow-up procedures in this situation will help ensure continuity of care and enhance patient safety.

Recommendations

1. Develop a process for the follow-up of patients who have missed or cancelled appointments.
2. Physicians should be notified of all missed or cancelled appointments on a daily basis.
3. The physician should assess the clinical importance of the appointment, the severity of the patient's medical condition, and the risk(s) associated with the missed or cancelled appointment to determine appropriate follow-up.
4. A reminder telephone call from the office staff may suffice for patients at minimal risk. The telephone call and the content of the message or conversation should be documented in the patient's record.
5. A telephone call from the physician may be indicated for patients at higher risk. The physician should emphasize the importance of follow-up care and the risks inherent in failing to comply. This conversation should also be documented in the medical record.
6. If there is no response from the patient, or the patient develops a pattern of not keeping or missing appointments, a letter with a certificate of mailing should be sent to the patient to advise him/her of the risk of noncompliance. A copy of the letter should be maintained in the patient's medical record.
7. All efforts to contact the patient, either by telephone or in writing, should be documented in the medical record. This provides evidence that the patient was made aware of the importance of continuous medical care.
8. Educate your staff regarding patient follow-up processes in your practice. Consider conducting periodic record reviews to evaluate the effectiveness of the established processes for patient follow-up.
9. Continued failure of a patient to keep appointments may be deemed noncompliance with treatment. Consideration should be given to discharging the patient from your practice. The attorneys of MLMIC's Legal Department are available to assist you in determining how and when to properly discontinue a physician–patient relationship due to patient noncompliance.

Follow-Up of Missed or Cancelled Appointments

A missed or cancelled appointment and the failure to follow up with or contact the patient may result in a serious delay in diagnosis or treatment. A well-defined process that includes provider notification and follow-up procedures in this situation will help ensure continuity of care and enhance patient safety.

	YES	NO
1. A process is in place for the follow-up of patients who have missed or cancelled appointments.	☐	☐
2. Providers are notified of all missed or cancelled appointments on a daily basis.	☐	☐
3. The provider assesses the clinical importance of the appointment, the severity of the patient's medical condition, and the risk(s) associated with the missed or cancelled appointment to determine the appropriate follow-up.	☐	☐
4. A reminder telephone call from the office staff may suffice for patients at minimal risk. The telephone call and the content of the message or conversation are documented in the patient's record.	☐	☐
5. A telephone call from the provider may be indicated for patients at higher risk. The provider should emphasize the importance of follow-up care and the risks inherent in failing to comply. This conversation is also documented in the medical record.	☐	☐
6. If there is no response from the patient, or the patient develops a pattern of not keeping or missing appointments, a letter with a certificate of mailing is sent to the patient to advise him/her of the risk of noncompliance. A copy of the letter is maintained in the patient's medical record.	☐	☐
7. All efforts to contact the patient, either by telephone or in writing, are documented in the medical record. This provides evidence that the patient was made aware of the importance of continuous medical care.	☐	☐

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Follow-Up of Missed or Cancelled Appointments

	YES	NO
8. Staff are educated regarding patient follow-up processes in our practice. Periodic record reviews are conducted to evaluate the effectiveness of the established processes for patient follow-up.	☐	☐
9. Continued failure of a patient to keep appointments may be deemed noncompliance with treatment. Consideration is given to discharging the patient from our practice.	☐	☐

The attorneys of MLMIC's Legal Department are available to assist you in determining how and when to properly discontinue a physician–patient relationship due to patient noncompliance. They may be reached at **(844) 667-5291**.

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 they were 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 should also 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.
    - 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 chaperone should be present even if the provider is the same gender as the patient.
5. Chaperones should be educated about patient privacy and confidentiality issues.
6. Unless specifically requested by the patient, family members should not be used as chaperones.
7. Respect for the patient's privacy can be further maintained by speaking to the patient privately before and/or after the examination.

Using Chaperones During Physical Examinations

Providers must recognize that, at any time, a patient can make a complaint to the Office of Professional Medical Conduct alleging that they were the victim of a provider's sexual misconduct. The presence of a chaperone during intimate physical examinations may be beneficial to both the provider 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 provider in the event of a misunderstanding or false accusation of sexual misconduct on the part of the patient.

	YES	NO
1. A chaperone is always used when performing breast or pelvic examinations.	☐	☐
2. Chaperones are considered for the following: • 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. • When a patient acts seductively or otherwise inappropriately.	☐	☐
3. The presence of a chaperone is always documented in the patient's medical record. • The provider can simply document "chaperone in room for the entire exam" and the chaperone's initials. • The name and title of the staff member who chaperoned the exam is added to verify their presence should the need arise at a later date.	☐	☐
4. Chaperones are educated about patient privacy and confidentiality issues.	☐	☐
5. Family members are not used as chaperones unless specifically requested by the patient.	☐	☐
6. Respect for the patient's privacy is further maintained by speaking to the patient privately before and/or after the examination.	☐	☐

A template indicating the use of a chaperone is available from MLMIC's Legal Department 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. It can be obtained by calling **(844) 667-5291**.

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.
    - Letters of complaint from third-party payors, IPRO, the New York State 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 well-being.
    - 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.

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Handling Patients' Complaints Properly

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 are 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.

Handling Patients' Complaints Properly

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 practices should have a policy or protocol in place to address patient complaints

	YES	NO
1. One individual has been identified and consistently used as the primary person to address patient complaints. This is often the office manager.	☐	☐
2. All staff know to whom complaints should be addressed, as well as what information constitutes a complaint that requires attention or intervention by that person. This, at a minimum, includes: • Written or verbal complaints regarding medical care. • Billing or payment issues that involve concerns about the clinical care. • Letters of complaint from third-party payors, IPRO, the New York State Department of Health, or other regulatory entities. Counsel is retained for assistance in formulating written responses to such agencies.	☐	☐
3. Effective communication skills are essential when addressing a patient complaint: • Concern for the patient's condition and well-being is expressed. • Staff are never adversarial or defensive. • Active listening is used, and questions are asked when appropriate. • Judgmental comments about patients and their families are avoided. • Negative remarks about staff, physicians, or other providers are avoided. • Complaints are investigated and follow-up is performed as indicated.	☐	☐
4. Conversations with patients are documented in the medical record. The patient is quoted when documenting their concerns.	☐	☐

Continued on next page.

Handling Patients' Complaints Properly

	YES	NO
5. Letters of response to complaints are concise and simple. A copy of the written response is kept in the patient's medical record.	☐	☐
6. When complaints involve clinical issues or are complex, physicians or other providers are involved in addressing the situation.	☐	☐
7. Attorneys' requests for records may be an indication of a patient's unhappiness. The patient's medical record is reviewed in conjunction with these requests in an effort to assess the potential for medical malpractice litigation.	☐	☐
8. Guidance is considered when presented with unusual or difficult situations. MLMIC staff are available to assist insureds with handling complaints, formulating responses, and determining potential exposure to claims of malpractice.	☐	☐
9. Contact with MLMIC or our attorneys is never documented in the patient's medical record.	☐	☐

The attorneys of MLMIC's Legal Department are available to assist in the proper handling of a patient complaint. They may be reached at **(844) 667-5291**.

The Proper Use of Scribes

The Risk

As the use of EHRs has become widespread, documentation practices and workflow patterns have changed significantly and have added to a growing clinical and administrative workload. The use of this technology has increased the amount of time necessary to complete medical record documentation and order entry.

One way that physicians have chosen to address these issues is through the use of scribes. Scribes originated in the fast-paced clinical setting of the emergency department (ED) as a way to reduce the time physicians needed to spend documenting care in an electronic format. The use of scribes has expanded from these roots in the ED to numerous other clinical settings. Scribes perform EHR data entry under the direct supervision of a licensed professional, freeing the physician or other provider to spend more time directly interacting with the patient.

As unlicensed members of the healthcare team, the recruitment, training, and supervision of scribes is paramount in managing their use in all clinical settings. Whether you are currently using scribes in your practice or are considering employing them, the following recommendations may be useful in evaluating your program or determining strategies for implementation.

Recommendations

1. Use documentation policies for your organization that comply with regulatory requirements. In addition, practices should monitor federal, state, and regulatory changes to maintain compliance with these guidelines.
2. Develop a written job description for scribes that outlines required qualifications and competencies, including proficiency with your EHR system and medical terminology. Clearly delineate job responsibilities.
3. Provide orientation that includes, but is not limited to, HIPAA, privacy regulations, organizational policies, and patient rights.

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The Proper Use of Scribes

4. Scribes should not perform any clinical functions or provide any direct patient care (unless they are otherwise a licensed healthcare provider, such as a licensed practical nurse or registered nurse). This includes:
    - Acting independently.
    - Touching patients.
    - Handling bodily fluids or specimens.
    - Translating for a patient.
    - Interpreting any information.
    - Conducting other duties while acting as a scribe.
5. Scribes should be assigned their own unique user ID/password credentials to access the EHR system. All entries to the record made by scribes must be while logged in with their own password and user ID. In the event that a licensed clinical staff member functions as a scribe, he/she must have two separate user IDs and passwords and use them accordingly.
6. Introduce the scribe to the patient, and give the patient the opportunity to decline having the scribe present during the examination.
7. The primary responsibility of the scribe should be to document the clinical encounter, including the history of present illness, a review of symptoms, the physical exam, and the assessment and plan, as presented by the provider. Scribes may also create pending orders as dictated by the provider. Providers must review and complete all medical orders.
8. All information entered into a medical record by a scribe must include:
    - The name of the patient and the provider providing care.
    - The date and time.
    - Authentication.
9. Providers must review the scribe's documentation and verify the entry. An attestation statement should include:
    - Affirmation of the provider's presence during the time the encounter was entered.
    - Confirmation that the provider reviewed the information and verified its accuracy.
    - Authentication, including date, time, name, and credentials.
10. Perform regular audits/assessments of the scribe's documentation, and provide constructive feedback for performance improvement, as indicated.

References:
https://www.jointcommission.org/standards/standard-faqs/ambulatory/record-of-care-treatment-and-services-rc/000002210/
https://www.ama-assn.org/practice-management/sustainability/overlooked-benefits-medical-scribes
https://www.aafp.org/fpm/2016/0700/p23.html

The Proper Use of Scribes

As the use of electronic health records (EHRs) has become widespread, documentation practices and workflow patterns have changed significantly and have added to a growing clinical and administrative workload. The use of this technology has increased the amount of time necessary to complete medical record documentation and order entry.

One way that physicians have chosen to address these issues is through the use of scribes. Scribes originated in the fast-paced clinical setting of the ED as a way to reduce the time physicians needed to spend documenting care in an electronic format. The use of scribes has expanded from these roots in the ED to numerous other clinical settings. Scribes perform EHR data entry under the direct supervision of a licensed professional, freeing the physician or other provider to spend more time directly interacting with the patient. As unlicensed members of the healthcare team, the recruitment, training, and supervision of scribes is paramount in managing their use in all clinical settings.

	YES	NO
1. Our organization's documentation policies comply with regulatory requirements. Federal, state, and regulatory changes are monitored to maintain compliance with these guidelines.	☐	☐
2. A written job description has been developed for scribes that outlines required qualifications and competencies, including proficiency with our EHR system and medical terminology. Job responsibilities are clearly delineated.	☐	☐
3. Orientation is provided for scribes that includes, but is not limited to, HIPAA, privacy regulations, organizational policies, and patient rights.	☐	☐
4. Scribes do not perform any clinical functions or provide any direct patient care (unless they are otherwise a licensed healthcare provider, such as a licensed practical nurse or registered nurse). This includes: • Acting independently. • Touching patients. • Handling bodily fluids or specimens. • Translating for a patient. • Interpreting any information. • Conducting other duties while acting as a scribe.	☐	☐

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The Proper Use of Scribes

	YES	NO
5. Scribes are assigned their own unique user ID/password credentials to access the EHR system. All entries to the record made by scribes are done while logged in with their own password and user ID. In the event that a licensed clinical staff member functions as a scribe, he/she has two separate user IDs and passwords and uses them accordingly.	☐	☐
6. The scribe is introduced to the patient, and the patient is given the opportunity to decline having the scribe present during the examination.	☐	☐
7. The primary responsibility of the scribe is to document the clinical encounter, including the history of present illness, a review of symptoms, the physical exam, and the assessment and plan, as presented by the provider. Scribes may also create pending orders as dictated by the provider. Providers review and complete all medical orders.	☐	☐
8. All information entered into a medical record by a scribe includes: • The name of the patient and the provider providing care. • The date and time. • Authentication.	☐	☐
9. Providers review the scribe's documentation and verify the entry. An attestation statement includes: • Affirmation of the provider's presence during the time the encounter was entered. • Confirmation that the provider reviewed the information and verified its accuracy. • Authentication, including date, time, name, and credentials.	☐	☐
10. Regular audits/assessments of the scribe's documentation are performed, and constructive feedback for performance improvement is provided.	☐	☐

2

Communication and the Physician–Patient Relationship

Management and Documentation of After-Hours Telephone Calls From Patients

The Risk

The failure to properly handle and document after-hours telephone calls can adversely affect patient care and lead to potential liability exposure for the physician. Should an undocumented telephone conversation become an issue in a lawsuit, the jury is less likely to believe the recollection of the physician, who receives a large number of calls on a daily basis.

Recommendations

1. Establish a system to help ensure that all after-hours calls are responded to in a reasonable time frame and documented in the patient's medical record.
2. Medical record documentation of after-hours calls should include the following:
    - The patient's name.
    - Name of the caller if he/she is not the patient, and the individual's relationship to the patient.
    - Date and time of the call.
    - Reason or nature of the call, including a description of the patient's symptoms or complaints.
    - Medical advice or information that was provided, including any medications that were prescribed.
3. If the patient's condition warrants the prescription of medications, it is important to inquire about and document any medication allergies, as well as any other medications the patient is currently taking.
4. If you use an answering service, it should be periodically evaluated for courtesy, efficiency, accuracy, and proper recordkeeping.

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Management and Documentation of After-Hours Telephone Calls From Patients

5. The use of answering machines or voicemail systems for after-hours calls is not recommended for the following reasons:
    - There are no safeguards in the event of a malfunction.
    - Patients do not always understand that no one will call back, even if this is stated in the message.
    - If, as a last resort, an answering machine or voicemail must be used, the message should be brief and simple and include the following: "The office is now closed. If you believe you are experiencing a medical emergency, please disconnect and call 911."
6. When after-hours coverage is provided by another physician's practice, a process should be in place to ensure that documented telephone conversations are promptly forwarded to your office.

Management and Documentation of After-Hours Telephone Calls From Patients

The failure to properly handle and document after-hours telephone calls can adversely affect patient care and lead to potential liability exposure for the physician. Should an undocumented telephone conversation become an issue in a lawsuit, the jury is less likely to believe the recollection of the physician, who receives a large number of calls on a daily basis.

	YES	NO
1. A system is in place to help ensure that all after-hours calls are responded to in a reasonable time frame and are documented in the patient's medical record.	☐	☐
2. Medical record documentation of after-hours calls includes the following: • The patient's name. • Name of the caller if he/she is not the patient, and the individual's relationship to the patient. • Date and time of the call. • Reason or nature of the call, including a description of the patient's symptoms or complaints. • Medical advice or information that was provided, including any medications that were prescribed.	☐	☐
3. If the patient's condition warrants the prescription of medications, inquires are made and documented about whether the patient has any medication allergies and is currently taking any other medications.	☐	☐
4. If used, the answering service is periodically evaluated for courtesy, efficiency, accuracy, and proper recordkeeping.	☐	☐
5. When after-hours coverage is provided by another provider's practice, a process is in place to ensure that documented telephone conversations are promptly forwarded to our office.	☐	☐

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Management and Documentation of After-Hours Telephone Calls From Patients

	YES	NO
6. When using an answering machine or voicemail for after hours calls, the message is brief and includes the following: "The office is now closed. If you believe you are experiencing a medical emergency, please disconnect and call 911."[1]	☐	☐

[1] Answering machines or voicemail systems for after-hours calls are not recommended, as there are no safeguards in the event of a malfunction. In addition, patients do not always understand that no one will call back, even if this is stated in the message.

Effective Communication With Patients

The Risk

Effective communication is the cornerstone of the physician–patient relationship. Patients' perceptions of physician communication skills may impact the potential for allegations of malpractice. The following suggestions are designed to promote open communication and help you reach an accurate diagnosis and develop an appropriate plan of care.

Recommendations

1. Employ active listening techniques, and allow the patient sufficient time to voice their concerns.
2. Sit at the level of the patient and maintain eye contact.
3. Assess the patient's literacy level. This may be as simple as asking what the highest grade level the patient attained is (https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html).
4. Use lay terminology when communicating with patients and their families.
5. Develop plans to communicate with patients who are hearing impaired or have limited English proficiency (https://www.ada.gov/effective-comm.htm).
6. Utilize the teach-back method when providing patients with instructions and information. This technique requires that patients repeat the information provided in their own words. The teach-back method is particularly useful in assessing patients' understanding of:
    - Informed consent discussions.
    - Medication instructions, including side effects and adverse reactions.
    - Test preparation.
    - Follow-up instructions.

    If the patient is unable to convey the information, it should be restated in simpler terms, perhaps by utilizing pictures and/or drawings.

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Effective Communication With Patients

7. Evaluate your educational tools and consent forms to determine the grade level at which they are written. This will allow you to provide written materials that are understandable to the majority of your patient population. Techniques that determine the readability and comprehension levels of documents are available from numerous sources, including:
    - https://www.cms.gov/outreach-and-education/outreach/writtenmaterialstoolkit/downloads/toolkitpart11.pdf
    - http://www.readabilityformulas.com/
8. At the conclusion of your patient encounter, ask the patient/family if they have any questions or concerns that have not been addressed.
9. Medical record documentation should reflect all aspects of patient interactions and comprehension. This will demonstrate the effectiveness of your communication skills and promote patient satisfaction, which may reduce your potential exposure to claims of malpractice.

Effective Communication With Patients

Effective communication is the cornerstone of the physician–patient relationship. Patients' perceptions of physician communication skills may impact the potential for allegations of malpractice. The following suggestions are designed to promote open communication and help you reach an accurate diagnosis and develop an appropriate plan of care.

	YES	NO
1. Active listening techniques are used, and patients are allowed sufficient time to voice their concern.	☐	☐
2. Providers sit at the level of the patient and maintain eye contact.	☐	☐
3. The patient's literacy level is assessed. This may be as simple as asking what the highest grade level the patient attained is.	☐	☐
4. Lay terminology is used when communicating with patients and their families.	☐	☐
5. Procedures are in place to communicate with patients who are hearing impaired or have limited English proficiency.	☐	☐
6. The teach-back method is used when providing patients with instructions and information. This technique requires that patients repeat the information presented in their own words. The teach-back method is particularly useful in assessing patients' understanding of: • Informed consent discussions. • Medication instructions, including side effects and adverse reactions. • Test preparation. • Follow-up instructions. If the patient is unable to convey the information, it is restated in simpler terms, perhaps by utilizing pictures and/or drawings.	☐	☐

Continued on next page.

Effective Communication With Patients

	YES	NO
7. Educational tools and consent forms have been evaluated to determine the grade level at which they are written. This allows for the provision of written materials that are understandable to the majority of our patient population.	☐	☐
8. At the conclusion of each patient encounter, the patient/family is asked if they have any questions or concerns that have not been addressed.	☐	☐
9. Medical record documentation reflects all aspects of patient interactions and comprehension. This demonstrates the effectiveness of our communication skills and promotes patient satisfaction.	☐	☐

Promoting Communication Between Referring and Consulting Providers

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 providers 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 provider.
3. All consultation reports must be reviewed by the referring physician prior to being placed in the patient's medical record.
4. If a patient has been noncompliant 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.
    - 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 and notification of the referring physician.
8. All telephone conversations between referring and consulting providers should be documented. Timely communication must occur when an urgent or emergent clinical finding is identified.

Promoting Communication Between Referring and Consulting Providers

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 providers will promote safe and effective patient care.

	YES	NO
1. A tracking system is in place to determine if the patient obtained the recommended consultation.	☐	☐
2. There is a process for determining whether a report has been received from the consulting provider.	☐	☐
3. All consultation reports are reviewed by the referring provider prior to being placed in the patient's medical record.	☐	☐
4. If a patient has been noncompliant in obtaining the recommended consultation, follow-up is performed. All attempts to contact the patient and any discussions with the patient, including reinforcement of the necessity and reason for the consultation, are documented.	☐	☐
5. If a report is not received in a timely manner, the consultant is contacted to determine if the patient has been seen and whether a report has been generated.	☐	☐
6. Consultants send reports to referring physicians in a timely manner. These reports should include the: • Findings. • Recommendations, including interventions. • Delineation of provider responsibility for treatment and the follow-up of test results.	☐	☐

Continued on next page.

Promoting Communication Between Referring and Consulting Providers

	YES	NO
7. The consultant contacts the referring provider when a patient fails to keep an appointment. The medical record reflects the missed appointment as well as the notification of the referring provider.	☐	☐
8. All telephone conversations between referring and consulting providers are documented. Timely communication occurs when an urgent or emergent clinical finding is identified.	☐	☐

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/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 EHR 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 ED. 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.

Communicating and Following Up Critical Test Results

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 provider orders a test, he/she is responsible for ensuring that the results have been received and reviewed. Provider practices should have policies and procedures in place for the management of test results.

	YES	NO
1. All ordered tests are documented in the patient's medical record.	☐	☐
2. A process is in place to confirm and document the receipt of test results. Our EHR system allows our practice to efficiently track pending laboratory/diagnostic studies.	☐	☐
3. Patients are advised of all test results, normal or abnormal. This communication is documented in the medical record.	☐	☐
4. All incoming laboratory reports and diagnostic tests are reviewed and authenticated by the provider.	☐	☐
5. The provider documents communication of the test results to the patient. Any recommendations or interventions are also documented.	☐	☐
6. A system is in place for the follow-up of pending laboratory/diagnostic test results for patients who have been discharged from the hospital or ED. Receipt and review of these results are documented in the patient's medical record. Communication of the results to the patient is also documented.	☐	☐
7. Provider responsibility for follow-up when tests are ordered for a patient by another specialist or consultant is clearly established.	☐	☐

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 nonprinted 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. Try asking "What questions do you have for me?" instead of "Do you have any questions?"
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, and then ask patients to repeat back the information they just heard in 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.

Communicating With Low-Health Literacy Patients

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.

	YES	NO
1. Lay terminology is used whenever possible. Technical terms are defined with simple language. Patient education materials are written in plain language, avoiding the use of medical jargon.	☐	☐
2. Verbal instructions are reinforced with visual aids and printed materials that are easy to read and include pictures, models, and illustrations. Consideration is given to the use of nonprinted materials, such as videos and audio recordings, as indicated.	☐	☐
3. Assistance is offered to patients when completing new patient information or any other practice documents. This help is provided in a confidential way and in an area that is private and conducive to this type of information exchange. Patients are encouraged to contact our practice with any further questions.	☐	☐
4. Interpreters are used, if indicated, for patients who are not fluent in the English language.	☐	☐
5. Open-ended questions are used at the end of the encounter, rather than yes/no questions, to further assess patient understanding. We say "What questions do you have for me?" instead of "Do you have any questions?".	☐	☐
6. Providers and staff are familiar with and utilize the principles of the teach-back method when reviewing new medications or treatment plans with patients. First, teach the information, and then ask patients to repeat it back in their own words.	☐	☐
7. Patients and family members may be embarrassed by or unaware of their healthcare literacy deficits. Our providers use an empathetic approach to understanding patient health literacy to enhance the physician–patient relationship.	☐	☐

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, failure 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 MLMIC's Legal Department 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 physicians discharge patients are:
    - Nonpayment.
    - Noncompliance with the physician's recommendations.
    - Disruptions in the physician–patient relationship.
4. The discharge is to be effective as of the date of the letter.
5. Refer the patient to the local county medical society, his/her 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 that it cannot be refused/unclaimed by the patient and can be forwarded if the patient has moved.

Continued on next page.

Discontinuing the Physician–Patient Relationship Properly

8. When the patient to be discharged is in need of urgent or emergent care or continuous care, is more than 24 weeks pregnant, or has a disability protected by state and federal discrimination laws, the question of whether the patient can be discharged should first be discussed with counsel, since discharge may not always be possible.
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 his/her new physician upon receipt of 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 led to the discharge in the patient's record.

Form letters and a memorandum on the discharge of patients are available from MLMIC's Legal Department.

Discontinuing the Physician–Patient Relationship Properly

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, failure 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.

	YES	NO
1. A formal patient discharge is made in writing. The patient is given at least 30 days from the date of the letter to call for an emergency in order to avoid allegations of abandonment. This time period may be longer depending on the patient's condition and the availability of alternative care.	☐	☐
2. The discharge is effective as of the date of the letter.	☐	☐
3. The patient is referred to the local county medical society, his/her health insurer, or a hospital referral source to obtain the names of other physicians.	☐	☐
4. The patient is provided with prescriptions for an adequate supply of medication or other treatment during the 30-day emergency period.	☐	☐
5. The discharge letter is sent using the USPS certificate of mailing procedure, not certified mail, so that it cannot be refused/unclaimed by the patient and can be forwarded if the patient has moved.	☐	☐
6. When the patient to be discharged is in need of urgent or emergent care or continuous care, is more than 24 weeks pregnant, or has a disability protected by state and federal discrimination laws, the question of whether the patient can be discharged is first discussed with counsel, since discharge may not always be possible.	☐	☐
7. The requirements regarding any restrictions on discharge imposed by the third-party payors with whom we participate are known.	☐	☐

Continued on next page.

Discontinuing the Physician–Patient Relationship Properly

	YES	NO
8. The patient's records are promptly sent to his/her new provider upon receipt of proper authorization.	☐	☐
9. The office computer or other appointment system is flagged to avoid giving the patient a new appointment after discharge.	☐	☐
10. The issues that led to the discharge are documented in the patient's record.	☐	☐

The discharge of each patient is determined by the physician on an individual basis and based on medical record documentation of patient noncompliance or disruption. MLMIC's Legal Department can be contacted for specific advice on the discharge of a noncompliant or disruptive patient. Form letters and a memorandum on the discharge of patients are also available. Contact MLMIC's Legal Department at **(844) 667-5291**.

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 and 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 nonexistent 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 to 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 not 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.

Continued on next page.

Treating Patients With Whom You Have a Close Relationship

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 New York State Prescription Monitoring Program (I-STOP) registry, and document that in the medical record.
7. When a surgical procedure is to be performed:
    - A signed informed consent form must be obtained and placed in the medical record.
    - The medical record must contain documentation that the informed consent conversation with the patient has occurred and that the patient consented to the procedure.

Treating Patients With Whom You Have a Close Relationship

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 and colleagues and even their own family members because of care they have provided. The defense of these suits is frequently hampered by the fact that there are often sparse or entirely nonexistent 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.

	YES	NO
1. A medical record is always created for friends, relatives, and colleagues when care of any kind is provided.	☐	☐
2. All patient encounters are documented in the medical record, including those that occur outside the medical office.	☐	☐
3. A complete medical history is taken when seeing friends, relatives, or colleagues as patients. If indicated, this includes issues that may be uncomfortable to discuss, such as the use of psychotropic medications or sexual history.	☐	☐
4. A thorough medication history is obtained from the patient to avoid potential drug interactions. Any contraindications are identified when prescribing medication.	☐	☐
5. A thorough physical examination is performed. Sensitive portions of the physical examination are not deferred when pertinent to the patient's complaints. These may include breast, pelvic, or rectal examinations. A chaperone is used for those portions of the examination.	☐	☐

Continued on next page.

Treating Patients With Whom You Have a Close Relationship

	YES	NO
6. Prescriptions are not written, especially for controlled substances, for individuals with whom we do not have an established professional relationship. The reasons for prescribing medications along with the dose are always documented. If narcotics are prescribed, the I-STOP registry is consulted and this is documented in the medical record.	☐	☐
7. When a surgical procedure is to be performed: • A signed informed consent form is obtained and placed in the medical record. • The medical record contains documentation that the informed consent conversation with the patient has occurred and that the patient consented to the procedure.	☐	☐

Managing Patient Noncompliance

The Risk

Patient noncompliance is one of the most difficult challenges for healthcare providers. Noncompliance may include missed appointments and failure to follow a plan of care, take medications as prescribed, or obtain recommended tests or consultations. The reasons given by patients for noncompliance vary but may include denial that there is a health problem, the cost of treatment, fear of the procedure or diagnosis, and not understanding the need for care. Physicians and other healthcare providers need to identify the reasons for noncompliance and document their efforts to resolve the underlying issues. Documentation of noncompliance helps protect providers in the event of an untoward outcome and allegations of negligence in treating the patient.

Recommendations

1. Establish an office policy to notify providers promptly of all missed and cancelled appointments. We recommend that this be done on a daily basis.
2. Formalize a process for follow-up with patients who have missed or cancelled appointments, tests, or procedures. This process should include recognition of the nature and severity of the patient's clinical condition to determine how vigorous follow-up should be.
    - Consider having the physician make a telephone call to the patient as a first step when the patient's condition is serious.
    - If the patient's clinical condition is stable or uncomplicated, staff should call the patient to ascertain the reason for the missed or cancelled appointment.
    - All attempts to contact the patient must be documented in the medical record.
    - If no response or compliance results, send a letter by certificate of mailing outlining the ramifications of continued noncompliance.
3. During patient visits, emphasize the importance of following the plan of care, taking medications as prescribed, and obtaining tests or consultations.
4. Seek the patient's input when establishing a plan of care and medication regimen. Socioeconomic factors may contribute to the patient's noncompliance.

Continued on next page.

Managing Patient Noncompliance

5. To reinforce patient education, provide simple written instructions regarding the plan of care. Use the teach-back method to confirm that patients understand the information and instructions provided.
6. With the patient's permission, include family members when discussing the plan of care and subsequent patient education in order to reinforce the importance of compliance.
7. When there is continued noncompliance, patient discharge from the practice may be necessary. The attorneys of MLMIC's Legal Department are available to discuss patient noncompliance and the discharge of a patient.

Managing Patient Noncompliance

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	YES	NO
1. An office policy is in place to notify providers promptly of all missed and cancelled appointments. This is done on a daily basis.	☐	☐
2. A formal process is in place for follow-up with patients who have missed or cancelled appointments, tests, or procedures. This process includes recognition of the nature and severity of the patient's clinical condition to determine how vigorous follow-up should be. • The physician makes a telephone call to the patient as a first step when the patient's condition is serious. • If the patient's clinical condition is stable or uncomplicated, staff call the patient to ascertain the reason for the missed or cancelled appointment. • All attempts to contact the patient are documented in the medical record. • If no response or compliance results, a letter is sent by certificate of mailing outlining the ramifications of continued noncompliance.	☐	☐
3. During patient visits, the importance of following the plan of care, taking medications as prescribed, and obtaining tests or consultations are emphasized.	☐	☐
4. The patient's input is sought when establishing a plan of care and medication regimen. Socioeconomic factors may contribute to the patient's noncompliance.	☐	☐

Continued on next page.

Managing Patient Noncompliance

	YES	NO
5. To reinforce patient education, simple written instructions are provided regarding the plan of care. The teach-back method is used to confirm that patients understand the information and instructions provided.	☐	☐
6. With the patient's permission, family members are included when discussing the plan of care and subsequent patient education in order to reinforce the importance of compliance.	☐	☐

The attorneys of MLMIC's Legal Department are available to discuss continued patient noncompliance and the possible discharge of a patient. They can be reached at **(844) 667-5291.**

3

Patient Safety and Medication Management

Management of Medical Equipment for Patient Care

The Risk

Many procedures are performed in the office setting using physician-owned or leased medical equipment. The failure or malfunction of this equipment may lead to patient, staff, or provider injury. The appropriate maintenance of this equipment is essential to patient safety.

Recommendations

1. A process should be in place for the maintenance of medical equipment. The manufacturers' directions for use and recommended preventative maintenance schedules should be followed.
2. A record of all maintenance activities should be generated and retained.
3. All patient care equipment should be inspected on an annual basis at a minimum or more often if recommended by the manufacturer.
4. Equipment should be labeled with the inspection date, the initials of the inspector, and the date the next inspection is due.
5. A designated staff member should confirm that all required inspections and preventative maintenance of equipment are performed at appropriate intervals.
6. Relevant staff should be properly trained in the use of medical equipment. Documentation of training and education should be maintained in their personnel files.
7. The scope of practice of medical personnel/licensed staff must be considered when they perform or assist in a procedure and/or use medical equipment.
8. A process should be in place that requires the immediate removal of malfunctioning equipment from use in the practice. This process should include a provision to sequester any piece of equipment that may be directly involved in injury to a patient, staff member, or provider. Prompt notification to your medical professional liability insurance carrier is recommended when an equipment-related patient injury occurs.

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Management of Medical Equipment for Patient Care

Many procedures are performed in the office setting using physician-owned or leased medical equipment. The failure or malfunction of this equipment may lead to patient, staff, or provider injury. The appropriate maintenance of this equipment is essential to patient safety.

	YES	NO
1. A process is in place for the maintenance of medical equipment. The manufacturers' directions for use and recommended preventative maintenance schedules are followed.	☐	☐
2. All patient care equipment is inspected on an annual basis at a minimum or more often if recommended by the manufacturer.	☐	☐
3. A designated staff member confirms that all required inspections and preventative maintenance of equipment are performed at appropriate intervals.	☐	☐
4. A record of all maintenance activities is generated and retained.	☐	☐
5. Equipment is labeled with the inspection date, the initials of the inspector, and the date the next inspection is due.	☐	☐
6. Relevant staff are properly trained in the use of medical equipment. Documentation of training and education is maintained in their personnel files.	☐	☐
7. The scope of practice of medical personnel/licensed staff is considered when they perform or assist in a procedure and/or use medical equipment.	☐	☐
8. A process is in place that requires the immediate removal of malfunctioning equipment from use in the practice. This process includes a provision to sequester any piece of equipment that may be directly involved in injury to a patient, staff member, or provider. MLMIC is promptly notified when an equipment-related patient injury occurs.	☐	☐

Safely Caring for Patients of Size in the Office Practice

The Risk

Obesity continues to be a serious health issue in the United States. Physicians' offices may not be well equipped to accommodate patients of size. Injuries can occur if appropriate equipment is not available to accommodate them. Further, bias or ambivalence by healthcare professionals in treating obese patients can negatively affect patient care and lead to poor outcomes. Providing a safe environment while optimizing sensitivity to the needs of this patient population will enhance patient care and minimize your exposure to claims of negligence.

Recommendations

1. Examination rooms and waiting areas should include appropriate and safe furnishings, such as large sturdy chairs, high sofas, benches, or loveseats that can accommodate patients of size and visitors.
2. Diagnostic and interventional equipment that can accommodate morbidly obese patients should be available. This may include but is not limited to:
    - Appropriate scales for patients who weigh more than 350 lbs.
    - Extra-large adult-sized blood pressure cuffs.
    - Gowns to accommodate patients weighing more than 350 lbs.
    - Extra-long phlebotomy needles and tourniquets.
    - Large examination tables.
    - Floor-mounted toilets.
    - Sturdy grab bars in bathrooms.
    - Sturdy step stools in examination rooms.
3. The office staff should be knowledgeable about the weight limits of their office equipment. Color-coded labels can be used to discreetly identify weight limits.
4. The office staff should be educated and trained in techniques to safely assist and transfer patients of size.

Continued on next page.

Safely Caring for Patients of Size in the Office Practice

5. Although patients of size may face many additional medical issues, they are less likely to obtain preventative care and more likely to postpone or cancel appointments because of embarrassment and/or a feeling of bias on the part of healthcare providers. Patient support and follow-up are important.
6. Healthcare providers should assess their own potential for weight bias, recognize any preconceived ideas and attitudes regarding weight, give appropriate feedback to patients to encourage healthful changes in behavior, and encourage patients to set goals and actively participate in their plan of care.
7. Staff should be educated about the needs of this patient population to enhance staff members' ability to demonstrate understanding, respect, and sensitivity.

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	YES	NO
1. Examination rooms and waiting areas include appropriate and safe furnishings, such as large sturdy chairs, high sofas, benches, or loveseats that can accommodate patients and visitors of size.	☐	☐
2. Diagnostic and interventional equipment that can accommodate morbidly obese patients is available. This may include but is not limited to: • Appropriate scales for patients who weigh more than 350 lbs. • Extra-large adult-sized blood pressure cuffs. • Gowns for patients weighing more than 350 lbs. • Extra-long phlebotomy needles and tourniquets. • Large examination tables. • Floor-mounted toilets. • Sturdy grab bars in bathrooms. • Sturdy step stools in examination rooms.	☐	☐
3. The office staff are knowledgeable about the weight limits of the office equipment. Color-coded labels are used to discreetly identify weight limits.	☐	☐
4. The office staff are educated and trained in techniques to safely assist and transfer patients of size.	☐	☐

Continued on next page.

Safely Caring for Patients of Size in the Office Practice

	YES	NO
5. Although patients of size may face many additional medical issues, they are less likely to obtain preventative care and more likely to postpone or cancel appointments because of embarrassment and/or a feeling of bias on the part of healthcare providers. Patient support and follow-up are provided.	☐	☐
6. Healthcare providers assess their own potential for weight bias, recognize any preconceived ideas and attitudes regarding weight, give appropriate feedback to patients to encourage healthful changes in behavior, and encourage patients to set goals and actively participate in their plan of care.	☐	☐
7. Staff are educated about the needs of this patient population to enhance their ability to demonstrate understanding, respect, and sensitivity.	☐	☐

Prescription Medications and Patient Safety

The Risk

Medication errors result in a significant portion of medical liability claims. Patient harm can result from known risks, adverse or allergic reactions, drug interactions, and errors in prescribing. Careful attention to detail in prescribing and monitoring the use of medications promotes patient health and safety.

Recommendations

1. Physicians must discuss the indications, risks, benefits, and alternatives of prescription medication with their patients and document these discussions in the medical record.
2. The patient's allergy history should be reviewed prior to prescribing.
3. Allergies/sensitivities should be documented in a highly visible and pertinent part of the record.
4. Medication reconciliation should be performed on a routine basis, including the use of herbal supplements and over-the-counter drugs. Patients should be encouraged to bring a list of medications or actual prescription bottles to their visit(s) to facilitate this process.
5. Written consent should be obtained for high-risk medications such as allergy shots, joint injections, fertility medications, chemotherapy, etc.
6. The blood levels/side effects of certain medications should be monitored with laboratory and/or diagnostic tests as indicated. Test results should be reviewed and adjustments made as necessary.
7. Discontinuance of or a change in medication(s) should be documented in the medical record, including the rationale for the change.
8. Patient visit intervals should be established for the continuance of prescription medications.

Prescription Medications and Patient Safety

Medication errors result in a significant portion of medical liability claims. Patient harm can result from known risks, adverse or allergic reactions, drug interactions, and errors in prescribing. Careful attention to detail in prescribing and monitoring the use of medications promotes patient health and safety.

	YES	NO
1. Providers discuss the indications, risks, benefits, and alternatives of prescription medication with their patients and document these discussions in the medical record.	☐	☐
2. Medication reconciliation is performed on a routine basis, including the use of herbal supplements and over-the-counter drugs. Patients are encouraged to bring a list of medications or actual prescription bottles to their visit(s) to facilitate this process.	☐	☐
3. The patient's allergy history is reviewed prior to prescribing.	☐	☐
4. Allergies/sensitivities are documented in highly visible and pertinent parts of the record.	☐	☐
5. Discontinuance of or a change in medication(s) is documented in the medical record, including the rationale for the change.	☐	☐
6. Written consent is obtained for high-risk medications such as allergy shots, joint injections, fertility medications, chemotherapy, etc.	☐	☐
7. The blood levels/side effects of certain medications are monitored with laboratory and/or diagnostic tests as indicated. Test results are reviewed and adjustments made as necessary.	☐	☐
8. Patient visit intervals are established for the continuance of prescription medications.	☐	☐

Managing Medication Samples

The Risk

Medication samples are widely used in a physician's office practice. A standard process should be in place for the proper handling, storage, dispensing, and disposal of medication samples. The safe management of medication samples can help prevent medication errors and subsequent patient injuries.

Recommendations

1. Develop policies and procedures for storing, handling, dispensing, and disposing of medication samples in your office practice.
2. Store medication samples in a safe and secure location in your office practice to reduce the risk of theft and unauthorized use. Limit access to medication samples to licensed staff members. These samples must not be kept in examination rooms or areas that are easily accessible to patients and visitors (e.g., in unlocked drawers or on countertops). Follow the manufacturer's recommendations for the storage of each drug.
3. Maintain a log of your supply of medication samples. The log should include documentation of the monitoring of expiration dates.
4. Assign the responsibility for monitoring and tracking the inventory of medication samples to a licensed staff member.
5. Explain the proper use of the medication to patients. Include any special instructions or warnings in that discussion, and document the same in the patient's medical record.
6. The sample medications should be labeled according to the provider's order with the same labeling requirements as a pharmacy. According to New York State Education Law §6807(1)(b), the label should include:
    - The name of the patient.
    - The name of the drug.
    - The dosage.
    - The name of the practitioner prescribing the medication.
    - How often to take the medication.
    - How much medication was prescribed (number of pills).
    - Special instructions on how to take the medication (e.g., with meals).
7. Properly dispose of expired medication samples in accordance with state, federal, and local laws.

Managing Medication Samples

Medication samples are widely used in a physician's office practice. A standard process should be in place for the proper handling, storage, dispensing, and disposal of medication samples. The safe management of medication samples can help prevent medication errors and subsequent patient injuries.

	YES	NO
1. Policies and procedures are in place for storing, handling, dispensing, and disposing of medication samples in the office practice.	☐	☐
2. Medication samples are stored in a safe and secure location in our office practice to reduce the risk of theft and unauthorized use. Access to medication samples is limited to licensed staff members. These samples are not kept in examination rooms or areas that are easily accessible to patients and visitors (e.g., in unlocked drawers or on countertops). The manufacturer's recommendations for storage of each drug are followed.	☐	☐
3. A log of medication samples is maintained. The log includes documentation of the monitoring of expiration dates.	☐	☐
4. The responsibility of monitoring and tracking the inventory of medication samples is assigned to a licensed staff member.	☐	☐
5. The provider or licensed professional explains the proper use of medication(s) to patients. Any special instructions or warnings are included in that discussion and are documented in the patient's medical record.	☐	☐
6. Sample medications are labeled according to the provider's order with the same labeling requirements as a pharmacy. According to New York State Education Law §6807(1)(b), the label should include: • The name of the patient. • The name of the drug. • The dosage. • The name of the practitioner prescribing the medication. • How often to take the medication. • How much medication was prescribed (number of pills). • Special instructions on how to take the medication (e.g., with meals).	☐	☐
7. Expired medication samples are disposed of in accordance with state, federal, and local laws.	☐	☐

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 interventions.

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 be advised to:
    - Keep an accurate list of all medications they take — 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.
    - Bring a list of all medications they are taking to each and every appointment.

Continued on next page.

Promoting Adherence to a Medication Regimen

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, and then ask patients to repeat it back in their own words.
8. Physicians should help patients manage their medications, caution them not to share medications, and advise them to follow storage recommendations and dispose of old medications properly.

Promoting Adherence to a Medication Regimen

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.

	YES	NO
1. Prescribing providers educate patients about each medication, including its name, appearance, purpose, and effect. This education includes any potential side effects and/or interactions associated with the medication regimen. The importance of contacting a healthcare provider should any reactions, questions, or concerns arise is also stressed.	☐	☐
2. Patients are queried 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 is emphasized to patients or their representatives.	☐	☐
4. Patients are advised to: • Keep an accurate list of all medications they take — 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 they are taking to each and every appointment.	☐	☐

Continued on next page.

Promoting Adherence to a Medication Regimen

	YES	NO
5. Patients are made aware of the various medication adherence aids and devices available, such as dosing reminders, pill boxes, and refill reminder programs.	☐	☐
6. Useful written information in plain language is provided that clearly explains how patients can correctly manage their medications.	☐	☐
7. The teach-back method is used when explaining medications to patients. First, teach the information, and then ask patients to repeat it back in their own words.	☐	☐
8. Providers help patients manage their medications, caution them not to share medications, and advise them to follow storage recommendations and dispose of old medications properly.		

Managing Patients With Chronic Pain

The Risk

The management of chronic pain through the prescription of controlled medication poses challenges and risks to both the patient and the healthcare provider. Common allegations against providers in pain management claims include:

- Liability for failing to adequately treat pain.
- Liability for allegedly inappropriately prescribing controlled substances.
- Potential for civil charges being brought against a physician or other provider for the patient's diversion of narcotics and/or drug abuse or overdose.
- Liability for failing to recognize a patient's addiction and/or diversion and not referring the patient for treatment.

Recommendations

1. Perform and document a thorough initial evaluation of the patient. This should include a history and assessment of the impact of the pain on the patient; the nature, type, and cause of the pain; and a focused physical examination to determine if there are objective signs and symptoms of pain. The provider should also review pertinent diagnostic studies, previous interventions, and drug history and assess the extent of coexisting medical conditions that impact the patient's pain. It is important to obtain the names of all other providers the patient is seeing or has seen and the pharmacies the patient uses.
2. Develop a specific treatment plan based on the evaluation.
3. Maintain accurate and complete medical records that clearly support the rationale for the proposed treatment plan.
4. Perform a thorough informed consent discussion regarding the plan of care, including the risks, benefits, and alternatives as well as the risks of the alternatives, such as no treatment with controlled substances.
5. Request the patient's consent to obtain copies of the records of all prior treating physicians, and review these records before prescribing controlled substances to determine if there is a history of drug-seeking behavior or drug abuse.
6. Use a written pain management agreement when prescribing controlled substances for

Continued on next page.

Managing Patients With Chronic Pain

patients with chronic pain. If the patient has a prior history of drug abuse, refer him/her to a pain management practice or clinic, if possible. A pain management agreement outlines the expectations of the provider and the responsibilities of the patient, including:

- A baseline screening of urine/serum medication levels.
- Periodic unannounced urine/serum toxicology screenings.
- Medications to be used, including dosage(s) and frequency of refills.
- A requirement that the patient receives medications from only one physician and uses only one pharmacy.
- The frequency of office visits.
- Any reasons for discontinuance of drug therapy (e.g., violation of agreement). A sample pain management agreement can be obtained by contacting MLMIC's Legal Department at **(844) 667-5291**.

7. Document and monitor all prescriptions and prescription refills.
8. Consult the I-STOP registry prior to prescribing any controlled pain medications. Document either that you have consulted the registry or the circumstances surrounding why consultation was not performed.
9. Protect prescription blanks if still utilized in your practice. Limit and monitor staff access to computer-generated prescriptions.
10. Take positive action if you suspect patient addiction or diversion. Public Health Law §3372 requires a physician to report to the New York State Department of Health Bureau of Narcotic Enforcement any patient who is reasonably believed to be a habitual user or abuser of controlled substances by calling (518) 402-0707.
11. Refer the patient for treatment of addiction, if appropriate, and document this discussion with the patient in the medical record.
12. If a patient is believed to be selling/diverting narcotics, and the patient's random urine test confirms no drug use or there has been a forgery or theft of prescriptions, contact MLMIC's Legal Department to discuss how to discharge the patient and how to handle requests for medications from the patient before the discharge is final.

Managing Patients With Chronic Pain

The management of chronic pain through the prescription of controlled medication poses challenges and risks to both the patient and the healthcare provider. Common allegations against providers in pain management claims include:

- Liability for failing to adequately treat pain.
- Liability for allegedly inappropriately prescribing controlled substances.
- Potential for civil charges being brought against a physician or other provider for the patient's diversion of narcotics and/or drug abuse or overdose.
- Liability for failing to recognize a patient's addiction and/or diversion and to refer the patient for treatment.

	YES	NO
1. A thorough initial evaluation of the patient is performed and documented. This includes a history and assessment of the impact of the pain on the patient; the nature, type, and causation of the pain; and a focused physical examination to determine if there are objective signs and symptoms of pain. The provider also reviews pertinent diagnostic studies, previous interventions, and drug history and assesses the extent of coexisting medical conditions that impact the patient's pain. The names of all other providers the patient is seeing or has seen and the pharmacies the patient uses are obtained.	☐	☐
2. A specific treatment plan is developed based on the evaluation.	☐	☐
3. Accurate and complete medical records are maintained that clearly support the rationale for the proposed treatment plan.	☐	☐
4. A thorough informed consent discussion is performed regarding the plan of care, including the risks, benefits, and alternatives as well as the risks of the alternatives, such as no treatment with controlled substances.	☐	☐
5. The patient's consent is requested to obtain copies of the records of all prior treating providers, and these records are reviewed prior to prescribing controlled substances to determine if there is a history of drug-seeking behavior or abuse.	☐	☐
6. All prescriptions and prescription refills are documented and monitored.	☐	☐

Continued on next page.

Managing Patients With Chronic Pain

	YES	NO
7. The I-STOP registry is consulted prior to prescribing any controlled pain medications. It is documented either that the registry has been consulted or the circumstances surrounding why a consultation was not performed.	☐	☐
8. Prescription pads, if still utilized in our practice, are protected from unauthorized use. Staff access to computer-generated prescriptions is limited and monitored.	☐	☐
9. A written pain management agreement is used when prescribing controlled substances for patients with chronic pain. If the patient has a prior history of drug abuse, the patient is referred to a pain management practice or clinic, if possible. A pain management agreement outlines the expectations of the provider and the responsibilities of the patient, including: • A baseline screening of urine/serum medication levels. • Periodic unannounced urine/serum toxicology screenings. • Medications to be used, including dosage(s) and frequency of refills. • A requirement that the patient receives medications from only one physician and uses only one pharmacy. • The frequency of office visits. • Any reasons for the discontinuance of drug therapy (e.g., violation of agreement).	☐	☐
10. Positive action is taken if we suspect patient addiction or diversion. (Public Health Law §3372 requires a physician to report to the New York State Department of Health Bureau of Narcotic Enforcement any patient who is reasonably believed to be a habitual user or abuser of controlled substances by calling (518) 402-0707.)	☐	☐
11. If appropriate, patients are referred for treatment of addiction, and this discussion with the patient is documented in the medical record.	☐	☐

The attorneys of MLMIC's Legal Department can provide sample pain management agreements or consultation when it is suspected that a patient may be selling or diverting narcotics. They can be reached at **(844) 667-5291**.

Managing Drug-Seeking Patients

The Risk

Healthcare professionals share in the responsibility to minimize 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 to healthcare providers when confronted with 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 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://www.health.ny.gov/professionals/narcotic/prescription_monitoring.
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 MLMIC's Legal Department) when prescribing controlled substances for chronic pain.
8. Specifically document drug treatment outcomes and the rationale for medication changes.

Continued on next page.

Managing Drug-Seeking Patients

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 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 Department of Health Bureau of Narcotic Enforcement. This is required by New York State Public Health Law §3372.
13. Contact MLMIC's Legal Department to discuss how to address a patient you believe is selling/diverting narcotics or altering, forging, or stealing prescription pads.

Managing Drug-Seeking Patients

Healthcare professionals share in the responsibility to minimize 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.

	YES	NO
1. A complete review of the patient's pertinent history is performed, and a thorough medical evaluation is conducted. All objective signs and symptoms of pain are addressed and documented.	☐	☐
2. Concern is exercised when caring for patients who are not interested in having a physical examination, are unwilling to authorize the release of prior medical records, have no interest in a diagnosis or a referral, or request an immediate narcotic prescription.	☐	☐
3. Caution is used if a new patient has unusual knowledge of controlled substances or requests a specific controlled substance and is unwilling to try any other medications.	☐	☐
4. A trial of non-narcotic medication and/or physical therapy is instituted and documented prior to prescribing the patient a controlled substance.	☐	☐
5. If the true source of a patient's pain is identified, we document that and any positive test results in the medical record.	☐	☐
6. The I-STOP registry is consulted before prescribing any Schedule II, III, or IV controlled substances.	☐	☐
7. The patient's informed consent for treatment of chronic pain with controlled substances is documented.	☐	☐
8. The patient signs a written pain management agreement.	☐	☐
9. Drug treatment outcomes and the rationale for medication changes are specifically documented.	☐	☐

Continued on next page.

Managing Drug-Seeking Patients

	YES	NO
10. An assessment of whether further treatment for addiction or pain management is completed, discussed with the patient, and documented. If necessary, the patient is referred for consultation to a pain management clinic or rehabilitation facility.	☐	☐
11. Official New York State Prescription pads are carefully monitored and protected if they are in use. Unless an exemption is applicable, prescriptions for controlled substances are electronically dispensed.	☐	☐
12. When electronically issuing or writing a prescription for controlled substances, the quantity and strength of drugs are written in both letters and numbers to prevent alteration.	☐	☐
13. Patients who are reasonably believed to be habitual users or abusers of controlled substances are reported to the New York State Department of Health Bureau of Narcotic Enforcement. This is required by New York State Public Health Law §3372.	☐	☐

The attorneys of MLMIC's Legal Department should be contacted to discuss how to address a patient believed to be selling/diverting narcotics or altering, forging, or stealing prescription pads.

Sample pain management agreements are available from MLMIC's Legal Department for use when prescribing controlled substances for chronic pain. They can be reached at **(844) 667-5291**.

4

Use of Technology (High Tech, Low Risk)

Reducing the Risk of the "Copy and Paste" Function in Electronic Health Records

The Risk

The "copy and paste" function of EHR systems 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, redundancy within the new entry may cause difficulty in identifying current information and create overly lengthy progress notes.

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 staff members' and providers' use of this function.
2. Educate all 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.
    - The importance of adhering to all regulatory, legal, and compliance guidelines.
3. Determine what portions of the record may 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 that 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 on 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 current.
7. Verify that the diagnoses in your assessment are only those addressed during that visit. Although some EHRs allow the copying of all diagnoses in the problem list, some may either have already been resolved or 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 that 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.

Reducing the Risk of the "Copy and Paste" Function in Electronic Health Records

The "copy and paste" function of EHR systems 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, redundancy within the new entry may cause difficulty in identifying current information and may create overly lengthy progress notes.

	YES	NO
1. A comprehensive policy and procedure for the appropriate use of the copy and paste function has been developed. Our policy includes a process to monitor and audit both staff members' and providers' use of this function.	☐	☐
2. EHR users are educated 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. • The importance of adhering to all regulatory, legal, and compliance guidelines.	☐	☐
3. It has been determined what portions of the record may be copied and pasted. At a minimum, the healthcare provider's signature(s) is not copied and pasted.	☐	☐
4. It has been confirmed that the source of information that has been copied and pasted can be readily identified and is available for review in the future.	☐	☐

Continued on next page.

Reducing the Risk of the "Copy and Paste" Function in Electronic Health Records

	YES	NO
5. It is confirmed that the history of the present illness is based on the patient's description during that visit.	☐	☐
6. The medical, social, or family history from a previous note is only used after it has been reviewed with the patient to confirm it is current.	☐	☐
7. The diagnoses in the assessment are only those addressed during that visit. Although some EHRs allow the copying of all diagnoses in the problem list, some may either have already been resolved or may not be relevant to this particular encounter.	☐	☐
8. Our EHR vendor is contacted as necessary to help our staff comply with established policies. This may include the vendor making modifications that 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.	☐	☐

The Use of Computers in Examination Rooms

The Risk

The presence of laptops/tablets in examination rooms has become commonplace as more providers implement EHRs. This method of documentation may place a barrier between the provider and the patient. Providers may miss nonverbal cues, and patients may perceive an electronic device as a hindrance to communication. In several recent medical malpractice cases, plaintiffs testified that the provider spent too much time entering information into the computer and not enough time listening. Utilizing effective communication skills to engage the patient while using a computer will enhance the integration of this technology into healthcare and improve the patient experience.

Recommendations

1. Analyze the examination room for placement of the computer. Position the computer in a way that enhances provider-patient communication. Consider using a cart on wheels to position the computer so that the provider faces the patient.
2. Establish eye contact with the patient, and listen to his/her concerns before using the computer. Look at the patient while you speak.
3. Reassure the patient that you are listening to him/her.
4. Utilize the POISED[1] model:
    - P = Prepare for the visit.
    - O = Orient the patient to what you are doing.
    - I = Information gathering — allow time for conversation.
    - S = Share what you are looking at on the screen with the patient.
    - E = Educate the patient, and reinforce the plan of action.
    - D = Debrief and assess the degree to which the patient understands the recommendations and plan. Utilize the teach-back method.
5. Print a copy of the visit for the patient, and retain a copy in the patient's record (e.g., after-visit summary).
6. When computers remain in examination rooms, providers must log off at the completion of the encounter to protect patient privacy.

[1] Frankel Ph.D., JAMA Internal Medicine commentary, November 30, 2015

The Use of Computers in Examination Rooms

The presence of laptops/tablets in examination rooms has become commonplace as more providers implement EHRs. This method of documentation may place a barrier between the provider and the patient. Providers may miss nonverbal cues, and patients may perceive an electronic device as a hindrance to communication. In several recent medical malpractice cases, plaintiffs testified that the provider spent too much time entering information into the computer and not enough time listening. Utilizing effective communication skills to engage the patient while using a computer will enhance the integration of this technology into healthcare and improve the patient experience.

	YES	NO
1. The examination room has been analyzed for placement of the computer. It is positioned in a way that enhances provider-patient communication. The use of a cart on wheels is considered to position the computer so that the provider faces the patient.	☐	☐
2. Eye contact is established with the patient, and his/her concerns are listened to before using the computer. Providers look at the patient while they speak.	☐	☐
3. Reassurance is given to the patient by our providers that demonstrates they are listening to him/her.	☐	☐
4. The POISED[1] model is utilized: • P = Prepare for the visit. • O = Orient the patient to what you are doing. • I = Information gathering — allow time for conversation. • S = Share what you are looking at on the screen with the patient. • E = Educate the patient, and reinforce the plan of action. • D = Debrief and assess the degree to which the patient understands the recommendations and plan. The teach-back method is used.	☐	☐
5. A print copy of the visit is provided to the patient, and a copy is retained in the patient's record (e.g., after-visit summary).	☐	☐
6. When computers remain in examination rooms, providers log off at the completion of the encounter to protect patient privacy.	☐	☐

[1] Frankel Ph.D., JAMA Internal Medicine commentary, November 30, 2015

The Proper Use of Patient Portals

The Risk

Patient portals are an effective tool to actively engage patients in their care and improve health outcomes. However, healthcare professionals must be aware of the potential risks presented by this technology. Some of these risks include reliance on the patient portal as a sole method of patient communication, patient transmission of urgent/emergent messages via the portal, the posting of critical diagnostic results prior to provider discussions with patients, and possible security breaches resulting in HIPAA violations. Implementing appropriate policies and procedures in the use of portals will enhance patient communication and mitigate liability risks for the practice.

Recommendations

1. Develop comprehensive patient portal policies that include:
    - Patient username and password requirements (i.e., a minimum number of characters that include capitals and nonalphabetic characters).
    - A privacy/confidentiality statement on all outgoing messages.
    - Encryption updates.
    - Account lockout after a specified number of failed login attempts.
    - A mechanism to ensure termination of user access when indicated (e.g., the patient leaves the practice, death, and inappropriate use of the portal).
    - Time frames for responding to patient communication.
    - Designated responsibility for replying to patients when the primary provider is not available.
    - Utilizing a two-factor identifier system for the importation of diagnostic studies into the patient portal.
    - Monitoring patient access to posted diagnostic results.
    - A follow-up system for patients who do not access the portal.
    - A mechanism to notify patients if the portal is not functioning properly. A notification should be placed on the practice's website and included in any prerecorded telephone message.

    Consider giving family members or patient representatives their own sign-in to the portal so that all can be on board with the recommended treatment plan.

Continued on next page.

The Proper Use of Patient Portals

2. Advise patients of the reporting mechanisms for:
    - Email address changes.
    - Questions regarding portal use.
    - Potential errors in their information.
    - Suspected breaches of privacy.
3. Providers should not use the portal as the means to communicate critical/significant diagnostic results. Diagnostic results should not be posted to the portal until this communication has occurred.
4. Instruct patients that the portal is not to be used to evaluate and treat new problems.
5. Utilize a disclaimer on the portal that clearly states it is not to be used for emergencies/urgent problems, and include instructions for patients to call 911 or go to the nearest ED.
6. Consider implementing a patient portal user agreement that:
    - Defines the information patients may access (e.g., appointments, medication refill and referral requests, form downloads, routine appointment reminders, and laboratory reports).
    - Prohibits requests for narcotic medication refills.
    - States that the patient portal is the only permissible method of electronic communication with the practice.
    - Includes the disclaimer statement regarding urgent/emergent/new problems.
7. Have staff educate patients regarding the use of the portal and the contents of the portal user agreement upon patient sign-up and as necessary.

For additional resources, please contact the attorneys of MLMIC's Legal Department.

The Proper Use of Patient Portals

Patient portals are an effective tool to actively engage patients in their care and improve health outcomes. However, healthcare professionals must be aware of the potential risks presented by this technology. Some of these risks include reliance on the patient portal as a sole method of patient communication, patient transmission of urgent/emergent messages via the portal, the posting of critical diagnostic results prior to provider discussions with patients, and possible security breaches resulting in HIPAA violations. Implementing appropriate policies and procedures in the use of portals will enhance patient communication and mitigate liability risks for the practice.

	YES	NO
1. Comprehensive patient portal policies have been developed, including: • Patient username and password requirements (i.e., a minimum number of characters that include capitals and nonalphabetic characters). • A privacy/confidentiality statement on all outgoing messages. • Encryption updates. • Account lockout after a specified number of failed login attempts. • A mechanism to ensure termination of user access when indicated (e.g., the patient leaves the practice, death, and inappropriate use of the portal). • Time frames for responding to patient communication. • Designated responsibility for replying to patients when the primary provider is not available. • Utilizing a two-factor identifier system for the importation of diagnostic studies into the patient portal. • Monitoring patient access to posted diagnostic results. • A follow-up system for patients who do not access the portal. • A mechanism to notify patients if the portal is not functioning properly. A notification should be placed on the practice's website and included in any prerecorded telephone message. We consider giving family members or patient representatives their own sign-in to the portal so that all can be on board with the recommended treatment plan.	☐	☐

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The Proper Use of Patient Portals

	YES	NO
2. Patients are advised of the reporting mechanisms for: • Email address changes. • Questions regarding portal use. • Potential errors in their information. • Suspected breaches of privacy.	☐	☐
3. Providers do not use the portal as the means to communicate critical/significant diagnostic results. Diagnostic results are not posted to the portal until this communication has occurred.	☐	☐
4. Patients are instructed that the portal is not to be used to evaluate and treat new problems.	☐	☐
5. A disclaimer is utilized on the portal that clearly states it is not to be used for emergencies/urgent problems and includes instructions for patients to call 911 or go to the nearest ED.	☐	☐
6. A patient portal user agreement is used that: • Defines the information patients may access (e.g., appointments, medication refill and referral requests, form downloads, routine appointment reminders, and laboratory reports). • Prohibits requests for narcotic medication refills. • States that the patient portal is the only permissible method of electronic communication with the practice. • Includes a disclaimer statement regarding urgent/emergent/new problems.	☐	☐
7. Staff educate patients regarding the use of the portal and the contents of the portal user agreement upon patient sign-up and as necessary.	☐	☐

Security of Patient Information and Health Information Technology

The Risk

With virtually all medical offices and healthcare facilities connected to the internet and using computer systems for the practice of medicine, maintaining the security of computers and other electronic devices as well as the privacy of patients' PHI has become critical.

The following are tips for staff and providers to secure this technology and information.

Recommendations

1. Require that staff and providers have strong and unique passwords:
    - Passwords should have a minimum of 12 characters and include uppercase and lowercase letters as well as numbers and symbols.
    - Passwords should be changed at set intervals.[1]
2. Do not share passwords. Do not allow others to document in an EHR under your password while you are logged on.
3. Grant staff access to an EHR only on a "need-to-know" basis:
    - Each individual should be granted access only to the information necessary to perform their job.
    - If an employee transfers to a different job function, have a process in place to reduce or increase their access based on the new job functions.
4. Educate staff not to:
    - Plug in their personal devices to USB ports on the system's computers.
    - Install software on their work computers without prior approval.
    - Click on suspicious links in emails.
    - Allow USB devices to leave the facility unencrypted.
5. Position computers and printers away from patient and visitor traffic and consider the use of screen filters to prevent PHI being seen by others.
6. Encrypt all computer hard drives. At a minimum, all laptops and tablets should be encrypted, especially if they are to leave the facility.

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Security of Patient Information and Health Information Technology

7. Provide frequent and ongoing cybersecurity education and training.
8. Policies and procedures should clearly define the disciplinary actions to be taken for inappropriate use of the computer system.
9. Develop a cybersecurity incident response process to address a security breach or cyberattack, and test it at least annually to confirm that there is:
    - A defined procedure for reporting any suspected information security incident.
    - An obligation for employees to report any suspected incident immediately upon discovery.
    - One or more individuals with clearly assigned responsibilities for managing incidents.
10. Promptly disable an individual's access to the computer system upon their leaving employment:
    - For involuntary dismissal, disable access prior to the notification of termination.
    - If access to the employee's emails, voicemail, etc., is necessary, assign another qualified individual to address any information that requires review or action.
11. Maintain inventory control of all computerized devices, including laptops, thumb drives, and handheld devices.
12. Install appropriate antivirus software, and update devices frequently to protect the computer system from security vulnerabilities.
13. Perform system back-ups of files and data routinely. Test back-up restoration semi-annually at a minimum.
14. Perform audits to ensure compliance with health information technology policies and any applicable regulations.

[1] Current guidelines suggest that if the password length is set to 16 characters, it should be changed annually at a minimum.

Security of Patient Information and Health Information Technology

With virtually all medical offices and healthcare facilities connected to the internet and using computer systems for the practice of medicine, maintaining the security of computers and other electronic devices as well as the privacy of patients' PHI has become critical.

	YES	NO
1. Staff and providers are required to have strong and unique passwords: • Passwords have a minimum of 12 characters and include uppercase and lowercase letters as well as numbers and symbols. • Passwords are changed at set intervals.[1]	☐	☐
2. Passwords are not shared and others are not allowed to document in an EHR under another person's password while they are logged on.	☐	☐
3. Staff are granted access to an EHR only on a "need to know" basis: • Individuals are granted access only to the information necessary to perform their job. • If an employee transfers to a different job function, a process is in place to reduce or increase his/her access based on the new job functions.	☐	☐
4. Staff have been educated not to: • Plug in their personal devices to USB ports on the system's computers. • Install software on their work computers without prior approval. • Click on suspicious links in emails. • Allow USB devices to leave the facility unencrypted.	☐	☐
5. Computers and printers are positioned away from patient and visitor traffic. The use of screen filters to prevent PHI being seen by others has been considered.	☐	☐
6. All computer hard drives are encrypted. At a minimum, all laptops and tablets are encrypted, especially if they leave the facility.	☐	☐

Continued on next page.

[1] Consult your IT provider for the appropriate interval.

Security of Patient Information and Health Information Technology

	YES	NO
7. Frequent and ongoing cybersecurity education and training are provided.	☐	☐
8. Policies and procedures clearly define the disciplinary actions to be taken for the inappropriate use of the computer system.	☐	☐
9. A cybersecurity incident response process has been developed to address a security breach or cyberattack, and it is tested at least annually to confirm that there is: • A defined procedure for reporting any suspected information security incident. • An obligation for employees to report any suspected incident immediately upon discovery. • One or more individuals with clearly assigned responsibilities for managing incidents.	☐	☐
10. An individual's access to the computer system is promptly disabled upon their leaving employment: • For involuntary dismissal, access is disabled prior to the notification of termination. • If access to the employee's emails, voicemail, etc. is necessary, another qualified individual is assigned to address any information that requires review or action.	☐	☐
11. Inventory control is maintained for all computerized devices, including laptops, thumb drives, and handheld devices.	☐	☐
12. Appropriate antivirus software has been installed, and devices are updated frequently to protect the computer system from security vulnerabilities.	☐	☐
13. System back-ups of files and data are performed routinely and back-up restoration is tested semi-annually at a minimum.	☐	☐
14. Audits are performed to ensure compliance with health information technology policies and any applicable regulations.	☐	☐

Managing Negative Online Reviews

The Risk

Healthcare providers recognize that, along with their practice websites, public websites such as Yelp, Healthgrades, and Rate MDs and social media sites such as Facebook and Twitter can be used as marketing tools to inform the public of their services. The online community, however, is then afforded an opportunity to respond, rate, and, at times, complain about those services. These statements and reviews are readily accessible to anyone with an internet-ready device to open and read.

While there is a basic instinct to immediately respond to negative online reviews, healthcare providers must remember that privacy rules make a complete response via social media inappropriate, and responding directly to an online post puts the healthcare provider at risk of disclosing PHI. Your response may not contain any identifying statements, but the mere recognition of a patient-provider relationship is a potential HIPAA violation.

The following tips will help you successfully and appropriately respond to negative online reviews.

Recommendations

1. Critically review all social media posts for accuracy and authenticity. While some negative statements regarding the performance of you or your staff may be difficult to read, evaluate these reviews to determine if there is an opportunity for learning or process change.
2. Do not become engaged in online arguments or retaliation — especially if the comments made are particularly negative and potentially detrimental to the reputation of the facility or physician.
3. According to federal and state confidentiality and privacy laws, providers are precluded from identifying patients on social media. In order to protect patient privacy, all patient concerns and complaints should be resolved by the practice by contacting the patient directly and not through social media.

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Managing Negative Online Reviews

4. If you do choose to respond via social media, use a standard response that also serves as a marketing opportunity for your practice. Some examples include:
    - "[Insert name] Medical Group is proud to have been providing comprehensive and compassionate care in the community since [insert year] and takes the treatment of our patients and their privacy seriously. Because federal privacy laws govern patients' protected health information, it is not the policy of [insert name] Medical Group to substantively respond to negative reviews on 'ratings' websites, even if they provide misleading, unfair, or inaccurate information. We welcome all our patients and their families to address any concerns/requests or information about their care with us directly, as we strive to continue to provide individualized care in our community."
    - "At our medical practice, we strive for patient satisfaction. However, we cannot discuss specific situations due to patient privacy regulations. We encourage those with questions or concerns to contact us directly at [insert phone number]."
5. If you feel the patient's complaint has disrupted the physician–patient relationship, consider discharging the patient from your practice. This action may be viewed as retaliatory by the patient and set off a new series of negative posts. Attorneys of MLMIC's Legal Department are available to assist you in making this decision.
6. Notify your local authorities if you feel at any time that your safety or the safety of your staff or family is threatened or at risk.

Managing Negative Online Reviews

Healthcare providers recognize that, along with their practice websites, public websites such as Yelp, Healthgrades, and Rate MDs and social media sites such as Facebook and Twitter can be used as marketing tools to inform the public of their services. The online community, however, is then afforded an opportunity to respond, rate, and, at times, complain about those services. These statements and reviews are readily accessible to anyone with an internet-ready device to open and read.

While there is a basic instinct to immediately respond to negative online reviews, healthcare providers must remember that privacy rules make a complete response via social media inappropriate, and responding directly to an online post puts the healthcare provider at risk of disclosing PHI. A response may not contain any identifying statements, but the mere recognition of a patient-provider relationship is a potential HIPAA violation.

	YES	NO
1. All social media posts are critically reviewed for accuracy and authenticity. While some negative statements regarding the performance of the providers or staff may be difficult to read, these reviews are evaluated to determine if there is an opportunity for learning or process change.	☐	☐
2. An online argument or retaliation is not participated in — especially if the comments made are particularly negative and potentially detrimental to the reputation of the facility or providers.	☐	☐
3. According to federal and state confidentiality and privacy laws, providers are precluded from identifying patients on social media. In order to protect patient privacy, all patient concerns and complaints are resolved by our practice by contacting the patient directly and not through social media.	☐	☐

Continued on next page.

Managing Negative Online Reviews

	YES	NO
4. A standard response that also serves as a marketing opportunity for our practice is used for social media responses. Some examples include: • "[Insert name] Medical Group is proud to have been providing comprehensive and compassionate care in the community since [insert year] and takes the treatment of our patients and their privacy seriously. Because federal privacy laws govern patients' protected health information, it is not the policy of [insert name] Medical Group to substantively respond to negative reviews on 'ratings' websites, even if they provide misleading, unfair, or inaccurate information. We welcome all our patients and their families to address any concerns/requests or information about their care with us directly, as we strive to continue to provide individualized care in our community." • "At our medical practice, we strive for patient satisfaction. However, we cannot discuss specific situations due to patient privacy regulations. We encourage those with questions or concerns to contact us directly at [insert phone number]."	☐	☐
5. Local authorities are notified if, at any time, the safety of staff is threatened or at risk.	☐	☐

If the patient's complaint has disrupted the physician–patient relationship, discharging the patient from your practice is considered. This action may be viewed as retaliatory by the patient and set off a new series of negative posts. Attorneys of MLMIC's Legal Department are available to assist with this process. They can be reached by at **(844) 667-5291**.

Utilizing Telehealth in Your Practice

The Risk

Telehealth continues to rapidly expand, due in large part to the COVID-19 pandemic, and is viewed as an effective method of healthcare delivery. It may reduce costs, increase access, decrease wait times, enhance patient compliance, and increase patient and family engagement. Conversely, the use of telehealth comes with considerable costs associated with obtaining the necessary equipment, unclear or evolving reimbursement issues, and an increased risk of privacy breaches. Patients and providers alike must also be motivated to buy into the process. Additionally, many providers have concerns that significant clinical signs and symptoms may be missed by distanced examinations.

A properly selected telehealth system can provide an effective format for healthcare delivery in the absence of an in-person visit. Many factors must be considered when implementing telehealth technology in your practice. The following recommendations will help you determine if the use of telehealth technology will benefit you and your patients.

Recommendations

1. Assess the needs of your providers and patients to determine which telehealth platform is best suited to your practice. This may include one or more platforms. The four main categories are:
    - Live videoconferencing
    - Asynchronous video (store-and-forward)
    - Remote patient monitoring
    - Mobile health
2. Waivers were put in place during the COVID-19 pandemic that allow for the use of Facetime and other non-HIPAA-complaint platforms. This will require diligent monitoring by the practice regarding the potential removal of such waivers in the future.
3. As part of the vendor selection process, ensure that they offer a secure, HIPAA-compliant platform that also provides data encryption and allows you to protect patient data and comply with privacy regulations and disclosure protocols in case of privacy breaches. Vendors must provide a Business Associate Agreement.

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Utilizing Telehealth in Your Practice

4. Include key staff and providers in the selection process to determine the best system for your practice and patient population. Explore the ability of the vendor(s) to customize options that fit your needs.
5. Create an informed consent process and a document for the use of telehealth services as recommended by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ).[1] Contact MLMIC's Legal Department at (844) 667-5291 to obtain a sample consent form.
6. Generate and retain formal documentation of all telehealth patient care visits. This documentation should be part of the patient's record, and all aspects of the encounter should be thoroughly documented.
7. Establish a monitoring program/quality improvement process to evaluate patient care outcomes and technical performance issues. Include questions regarding the telehealth experience in patient satisfaction surveys.
8. Prepare a contingency plan for use in case of a technology failure. Communicate any disruption in service to the patient as soon as possible in advance of a scheduled telehealth encounter.
9. Engage in continuing education to ensure key competencies are maintained. Both providers and staff should receive ongoing education regarding updates to the practice's telehealth system, along with refreshers on patient privacy and engaging patients via telehealth.

[1] https://www.ahrq.gov/health-literacy/improve/informed-consent/obtain.html

Utilizing Telehealth in Your Practice

Telehealth continues to rapidly expand, as it is viewed as an effective method of healthcare delivery. It may reduce costs, increase access, decrease wait times, enhance patient compliance, and increase patient and family engagement. Conversely, with the use of telehealth comes considerable costs associated with obtaining the necessary equipment, unclear or evolving reimbursement issues, and an increased risk of privacy breaches. Patients and providers alike must also be motivated to buy into the process. Additionally, many providers have concerns that significant clinical signs and symptoms may be missed by distanced examinations.

A properly selected telehealth system can provide an effective format for healthcare delivery absent an in-person visit. Many factors must be considered when implementing telehealth technology in your practice. The following recommendations will help you determine if the use of telehealth technology will benefit you and your patients.

	YES	NO
1. An assessment was performed to identify the telehealth platform(s) that best suit the practice, including consideration for: • Live Video-Conferencing • Asynchronous Video (Store-and-Forward) • Remote Patient Monitoring (RPM) • Mobile Health (mHealth)	☐	☐
2. The practice no longer relies upon waivers put into place during the COVID-19 pandemic for the use of FaceTime and other non-HIPAA complaint platforms.	☐	☐
3. Selected telehealth vendor offers a secure, HIPAA-compliant platform.	☐	☐
4. The platform offers data encryption and allows us to protect patient data.	☐	☐
5. The vendor confirmed that the platform complies with privacy regulations and disclosure protocols in case of privacy breaches.	☐	☐
6. An appropriate Business Associate Agreement is in place.	☐	☐

Continued on next page.

Utilizing Telehealth in Your Practice

	YES	NO
7. Key staff and providers have been included in the selection process to determine the best system for the practice and patient population.	☐	☐
8. The vendor can customize options that fit our needs.	☐	☐
9. An informed consent has been created for the use of telehealth services as recommended by the American Telehealth Association.[1]	☐	☐
10. All telehealth patient care encounters are documented in the patient's record.	☐	☐
11. A comprehensive monitoring program/quality improvement process has been developed to evaluate patient care outcomes and technical performance issues.	☐	☐
12. Questions regarding the telehealth experience are included in patient satisfaction surveys.	☐	☐
13. A contingency plan has been prepared in the event of a technology failure.	☐	☐
14. Patients are promptly notified of any technological issues, in advance of a scheduled telehealth encounter.	☐	☐
15. Staff have completed key competencies, with ongoing continuing education regarding: • updates to the practice's telehealth system • refreshers on patient privacy • engaging patients via telehealth	☐	☐

[1] https://www.americantelemed.org/resource/

Effective Telehealth Patient Engagement

The Risk

Telehealth emerged as an essential component of healthcare during the COVID-19 pandemic. Changes in permissible formats, adjustments to reimbursement, and the need for social distancing have contributed to the widespread acceptance of this technology, leading to a significant increase in telehealth visits.

The proliferation of telehealth highlights the need to implement effective strategies for patient engagement. While the move to "virtual visits" with healthcare providers was seamless for many segments of the population, this may not be the case for all patient populations. There are numerous factors to consider when determining whether a telehealth encounter is the right choice for an individual patient.

Recommendations

1. **Appropriateness:** The presenting condition or health concern must be amenable to the visit type. Practices may consider identifying diagnoses and symptoms or conditions that require in-person visits to use as a guide for patients and staff when scheduling virtual visits.
2. **Patient disabilities and impairments:** Healthcare professionals have a legal obligation to provide care equally to all their patients, including when telehealth is being utilized as an alternative to in-person treatment. Communication with a disabled person via telehealth must be as effective as with any other patient, and healthcare providers should consider using platforms that provide closed captioning for hearing-impaired patients. When language barriers are presented, providers should have access to an interpreter and consider using telehealth platforms that allow for three-way communication. Lastly, the patient's cognitive abilities and the availability of a support system, including family members or significant others, should be considered as part of the patient selection process.
3. **Access and compatibility:** The patient must have internet access and the appropriate equipment required to participate in the visit. An assessment of the location of the visit should be completed and patient consent obtained to ensure that HIPAA protections are in place.
4. **Commitment:** The patient must be personally invested and willing to actively participate in this mode of care delivery. In order to achieve a meaningful and successful healthcare encounter, both the provider and the patient must be fully engaged and committed to this format.

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Effective Telehealth Patient Engagement

5. **Use with seniors:** When evaluating the appropriateness of telemedicine visits for senior patients, consider the patient's hearing ability, as it is common for seniors to have some degree of hearing loss in conjunction with the aging process. He/she may also have some reduced vision from cataracts, macular degeneration, and/or other ocular issues. The following recommendations can help address these barriers and enhance the quality of the telemedicine visit:
    - Assess your location prior to initiating a telehealth visit:
        - Evaluate the lighting.
        - Avoid lights that cast shadows on your face so that facial expressions will be clearly seen and communicated.
    - Consider performing a "dry run" with your staff to identify any issues that might impact the experience for your patients.
    - When beginning the encounter, ask the senior patient if he/she can see and hear you clearly.
    - Minimize background noises and visual distractions when possible.
    - Remember to use nonverbal gestures to augment the spoken word.
    - Consider having the patient use headphones that allow for volume adjustment.
    - If indicated, use a platform that includes closed captioning.

Even though these visits are conducted remotely, be cognizant that the patient will also be able to visualize the encounter. When considering telehealth encounters, please see Risk Management Tip #21 on the effective use of computers in the examination room.

Effective Telehealth Patient Engagement

Telehealth became an essential component of healthcare during the COVID-19 crisis. Changes in permissible formats, adjustments to reimbursement, and the need for social distancing contributed to the widespread acceptance of this technology, leading to a significant increase in telehealth visits. Patients now embrace both the technology and convenience associated with these encounters.

The proliferation of telehealth highlights the need to implement effective strategies for patient engagement. While for many segments of the population the move to "virtual visits" with their healthcare providers was seamless, this may not be the case for all patient populations. There are numerous factors to consider when determining whether a telehealth encounter is the right choice for an individual patient and if the patient engagement is effective.

	YES	NO
1. Procedures are in place to determine if the patient's presenting condition or health concern is amenable to a telehealth visit. • Patients and staff can identify diagnoses and symptoms or conditions that require in-person visits when scheduling a visit.	☐	☐
2. The platform is suited to meet the needs of our patients with disabilities or impairments: • Hearing-impaired patients have been provided a closed captioning platform. • Where other language barriers exist, there is access to an interpreter, and consideration is given to platforms that allow for three-way communication. • Patients' cognitive abilities are assessed, and there is an available support system.	☐	☐
3. We verify that the patient has internet access and the appropriate equipment required to participate in the visit. • An assessment of the location of the visit was completed. • Patient consent was obtained, and HIPAA protections are in place.	☐	☐
4. The patient is evaluated and is personally invested and willing to actively participate in this mode of care delivery. Both the provider and the patient are fully engaged and committed to this format.	☐	☐

Continued on next page.

Effective Telehealth Patient Engagement

	YES	NO
5. At the end of each telehealth visit, patient/family are asked if they have any questions or concerns that have not been addressed.	☐	☐
6. The telehealth encounter has been documented in the record, including the patient's engagement and response to the format.	☐	☐
7. Staff have completed key competencies, with ongoing continuing education regarding engaging patients via telehealth.	☐	☐
8. Considerations for seniors: • Location has been assessed prior to initiating a telehealth visit. • The patient is asked if they can see and hear you clearly. • Lighting is evaluated, and lights that cast shadows on your face or obscure facial expressions are avoided. • Non-verbal gestures are used to augment the spoken word. • Background noises and visual distraction are kept to a minimum when possible. • Patients are encouraged to use headphones that allow for volume adjustment. • As noted above, consideration is given to using a platform that provides closed captioning. • Staff has performed a "dry run" to identify any issues that might impact your patient's experience.	☐	☐

Even though these visits are conducted remotely, be cognizant that the patient will also be able to visualize the encounter. When considering telehealth encounters, please see our Risk Management Tip: The Use of Computers in Examination Rooms.

Documentation Considerations for Open Notes

The Risk

The 21st Century Cures Act was enacted in part to increase communication among healthcare providers and remove some of the barriers patients face when trying to obtain their health information. To accomplish this, the Act affords both providers and patients greater access to more complete patient histories and empowers patients to become more engaged in their healthcare decisions. This improved patient engagement allows providers the opportunity to improve documentation accuracy, enhance patient safety, increase patient compliance, develop stronger patient relationships, improve the efficiency of care, and enhance the overall patient experience.

Considering the increased access patients have to their health information, the following strategies can help your patients better understand their records, become active participants in their healthcare, and create stronger physician–patient relationships.

Recommendations

1. Confirm with your EHR system vendor that all required information can be accessed by your patients, and review how that information will appear on their screen.
2. Understand and maximize the format and function of your EHR. For example, ensure applications such as portal access, spell check, and reminder notifications are functioning properly.
3. Consider the health literacy level of your patient.[1] Use plain language in your documentation whenever possible.
    - Avoid the use of jargon.
    - Define medical terms when possible. Consider providing a list of terms and abbreviations frequently used in your documentation.

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Documentation Considerations for Open Notes

4. Remember that how you document an encounter can have an effect on your patient. Consider the following in your documentation:
    - Be careful not to sound judgmental in your notes. Avoid terms that may be offensive or emotionally charged. For example, document "Patient reports s/he did not take the medications" vs. "noncompliant" or "unreliable."
    - Use objective measures such as BMI instead of saying "obese" or "overweight."
    - Be careful of using abbreviations, e.g., "[Patient] is 'SOB'."
    - Use a supportive tone when possible: "Lost five pounds and is motivated to continue" vs. "Still needs to lose another 15 pounds."
    - Document as though you are writing instructions: "Weigh yourself every morning" vs. "Patient needs to monitor weight."
    - Avoid using the copy and paste feature of your EHR. The information copied and pasted may be redundant, outdated, or inaccurate and create the wrong perception of your records.[2]
5. Engage your patients and solicit feedback from them:
    - Consider dictating or typing notes with the patient present; talk during the visit about what you are documenting.
    - Encourage your patients to refer to the notes, as this may help increase compliance with the treatment plan.
6. Ensure that your practice has the resources in place to support increased patient engagement. Have written policies and procedures to address:
    - How patients and their representative can access their health information.
    - The confidentiality of minors' information.
    - How to address patient comments or questions about the documentation of their encounter.
7. Provide educational information to patients on open notes:
    - Implement practice policies that address questions on patient access.
    - Increase communication and access through media such as:
        - Email
        - The patient portal
        - Your website
        - Social media
        - Information sheets and/or flyers in the office

[1] See MLMIC's Risk Management Tip: Communicating With Low Health Literacy Patients

[2] See MLMIC's Risk Management Tip: Reducing the Risk of the "Copy and Paste" Function in Electronic Health Records

Documentation Considerations for Open Notes

The 21st Century Cures Act was enacted in part to increase communication among healthcare providers and remove some of the barriers patients face when trying to obtain their health information. To accomplish this, the Act affords both providers and patients greater access to more complete patient histories and empowers patients to become more engaged in their healthcare decisions. This improved patient engagement allows providers the opportunity to improve documentation accuracy, enhance patient safety, increase patient compliance, develop stronger patient relationships, improve efficiency of care, and enhance the overall patient experience.

Considering the increased patient access to their health information, the following strategies can help our patients better understand their records, become active participants in their healthcare, and create stronger physician-patient relationships.

	YES	NO
1. The electronic health records (EHR) system vendor has confirmed that all required information can be accessed by our patients and how that information will appear on their screen.	☐	☐
2. EHR format is understood, functions are maximized, and applications such as portal access, spell check, and reminder notifications are functioning properly.	☐	☐
3. The patient remains engaged and feedback is solicited from them. • You dictate or type notes with the patient present; you talk during the visit about what you are documenting. • Patients are encouraged to refer to the notes as a reminder of the treatment plan to increase their compliance.	☐	☐
4. Resources are in place to support increased patient engagement. Written policies and procedures address: • How patients and their representative can access their health information • The confidentiality of minors' information • How patient comments or questions about the documentation of their encounter will be managed	☐	☐

Continued on next page.

Documentation Considerations for Open Notes

	YES	NO
5. Documentation of the encounter is assessed for negative effects it may have on our patient. Your documentation: • Does not sound judgmental. You avoid terms that may be offensive or emotionally charged. For example, document "Patient reports s/he did not take the medications" vs. "noncompliant" or "unreliable" • Uses objective measures like BMI vs. "obese" or "overweight" • Is mindful and care is taken when using abbreviations: "[Patient] is 'SOB'" • Uses a supportive tone when possible: "Lost five pounds and is motivated to continue" vs. "Still needs to lose another 15 pounds" • Emphasizes that you are writing clear instructions: "Weigh yourself every morning" vs. "Patient needs to monitor weight" • Avoids the copy and paste feature of your electronic record system, as the information copied and pasted may be redundant, outdated, or inaccurate and create the wrong perception about your records[1]	☐	☐
6. The health literacy level of our patient is assessed.[2] Plain language is used in your documentation: • Avoid the use of jargon • Define medical terms when possible. Consider providing a list of terms and abbreviations frequently used in your documentation.	☐	☐
7. Educational information is provided to patients on open notes: • A practice policy is implemented to address questions on patient access • How to increase communication and access through media such as: 1. Email 2. The patient portal 3. Your website 4. Social media 5. Information sheets and/or flyers in the office	☐	☐

[1] See MLMIC's Risk Management Tip: Reducing the Risk of the "Copy and Paste" Function in Electronic Health Records

[2] See MLMIC's Risk Management Tip: Communicating with Low Health Literacy Patients

Social Media Hygiene for Healthcare Organizations

The Risk

Healthcare communication continues to become more electronic, and while social media accounts tend toward a more casual communication style, healthcare providers must remain vigilant about the security of their platforms as well as the message they convey to their patients and potential patients.

Social media hygiene is a set of practices and behaviors related to cleaning up and maintaining your digital presence, in terms of both security and the message your social media applications deliver to patients and potential patients.[1] In much the same way as we wash our hands with soap and water regularly, it is also critical to follow those practices to keep you and your virtual data well protected and convey an appropriate message about your organization.

Recommendations

Performing proper social media hygiene is a two-step process, the first of which is system hygiene:

1. Regularly update all electronic devices and applications as recommended.
2. Use passwords that follow appropriate security protocols:
    - Longer passwords are more secure — eight or more characters are recommended.
    - Passwords should include different characters: numbers, symbols, and at least one capital letter.
    - Avoid recycling passwords.
    - Do not use the same password for all devices/apps/accounts.
    - Do not allow staff to share passwords.
3. Review the organization of files stored on your devices:
    - Determine that you have the right information and applications on the right device(s).
    - Define those files that are mobile-, laptop-, and/or PC-appropriate.
4. Optimize factory settings:
    - Use default settings as appropriate.
    - Know how to disable, lock, or erase information in the event of device theft.

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Social Media Hygiene for Healthcare Organizations

5. Use multifactor authentication to log into your social media accounts.
6. When possible, employ device encryption.
7. Lock down who can see your posts/information.

These steps are often cited as the best measures to employ for protection against cyberattacks. However, your cybersecurity must extend beyond your device to include the information that is attached to you and your practice.

Reviewing the information on your social media platforms is referred to as the profile hygiene portion and is the second step of this process:

1. Analyze your current social media profiles to determine if there is anything that:
    - Must be immediately addressed or can wait for revisions.
    - Is no longer current.
2. Clean up your digital past:
    - Delete old photos and posts that are no longer relevant.
    - Delete old and/or neglected social media accounts.
3. Ensure that the privacy settings on your platforms remain up to date.
4. Review your blog and website:
    - Ensure that all information remains relevant and accurate.
    - Consider whether the message presented about your practice is as you intend.
    - If links are embedded, test that they are still functional and appropriate to your message.
    - Delete any stale/nonfunctioning links, and, if appropriate, replace them with current information.

Routinely performing social media hygiene can help protect your practice from security breaches, keep your social media sites informative, and improve patient satisfaction.

[1] https://www.cloverinfotech.com/blog/cybercrime-is-infectious-digital-hygiene-is-the-vaccine/

Social Media Hygiene for Healthcare Organizations

Healthcare communication continues to become more electronic, and while social media accounts tend toward a more casual communication style, healthcare providers must remain vigilant about the security of their platforms, as well as the message they convey to their patients and potential patients.

Social Media Hygiene is a set of practices and behaviors related to cleaning up and maintaining your digital presence, in terms of both security and the message your social media applications deliver to patients and potential patients.[1] Much in the same way as we wash our hands with soap and water regularly, it is also critical to follow practices that will keep you and your virtual data well protected and convey an appropriate message about your organization.

Performing proper social media hygiene is a two-step process; the first is **system hygiene**:

	YES	NO
1. All electronic devices and applications have been updated, as recommended.	☐	☐
2. Passwords follow appropriate security protocols: • Longer passwords are more secure: eight or more characters is recommended. • Passwords should include different characters: numbers, symbols, and at least one capital letter. • Avoid recycling passwords. • Do not use the same password for all devices/apps/accounts. • Do not allow staff to share passwords.	☐	☐
3. The organization of files stored on your devices has been reviewed: • Determine that you have the right information and applications on the right device. • Define those files that are mobile, laptop, and PC-appropriate.	☐	☐
4. Factory settings have been optimized: • Default settings are used as appropriate. • Devices can be disabled, locked, or have information erased in the event of theft.	☐	☐

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[1] https://www.cloverinfotech.com/blog/cybercrime-is-infectious-digital-hygiene-is-the-vaccine/

Social Media Hygiene for Healthcare Organizations

	YES	NO
5. Multifactor authentication (MFA) is used for logging into your social media accounts.	☐	☐
6. Device encryption has been employed.	☐	☐
7. A lockdown of who can see your posts/information has been utilized.	☐	☐

These steps are often cited as the best measures to employ for protection against cyberattacks. However, your cybersecurity must extend beyond your devices to include the information that is attached to you and your practice.

Reviewing the information on your social media platforms is the **profile hygiene** portion and the second step of this process:

	YES	NO
1. Current media profiles have been analyzed to determine if there is anything that: • Must be immediately addressed or can wait for revisions • Is no longer current	☐	☐
2. Your organization's digital past has been cleaned: • Old photos and posts that are no longer relevant have been deleted. • Old and/or neglected social media accounts have been deleted.	☐	☐
3. Privacy settings on your platforms are up to date.	☐	☐
4. Blog and website have been reviewed: • All information is relevant and accurate. • The message presented about your practice is as you intended. • Embedded links are still functional and appropriate to your message. • Stale/non-functioning links, are deleted or replaced with current information.	☐	☐

Routinely performing social media hygiene can help protect your practice from security breaches, keep your social media sites informative, and improve patient satisfaction.