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## **Risk Management Tips** for Today's Medical Practice

Volume I





# Risk Management Tips

## for Today's Medical Practice

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

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# HIPAA REGULATIONS

## Tip #1: Maintaining Patient Confidentiality

**The Risk:** Patient confidentiality breaches pose a significant risk in the healthcare setting. 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, regarding 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. The staff should be advised to never discuss patients outside the office, including the use of social media.
5. Assess the flow of patients through the office 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 your Notice of Privacy Practices. Patients must be offered the option of opting out.
10. Business Associate Agreements must be obtained and maintained for all vendors who have access to PHI.

## Tip #2: 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 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 this conversation in the medical record.
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 record.
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 also should be in place to track consultations.

## Tip #3: 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.

## Tip #4: Management of Medical Equipment for Patient Care

**The Risk:** Many procedures are performed in the office setting using physician-owned or leased medical equipment. 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 maintenance of medical equipment. The manufacturers' directions for use and recommended preventative maintenance schedule 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 that the next inspection is due.
5. A designated staff member should confirm that all required inspections and preventative maintenance of equipment is 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 which may be directly involved in injury to a patient, staff, or provider. Prompt notification to your medical professional liability insurance carrier is recommended when an equipment-related patient injury occurs.



## Tip #5: 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 non-compliance. 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 non-compliance with treatment. Consideration should be given to discharging the patient from your practice. The attorneys at Fager Amsler Keller & Schoppmann, LLP are available to assist you in determining how and when to properly discontinue a physician-patient relationship due to patient non-compliance.



## Tip #6: 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 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 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 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:
  - Name of the patient
  - Name of drug
  - Dosage
  - Name of practitioner prescribing medication
  - How often to take medication
  - How much medication was prescribed (number of pills)
  - Special instructions on how to take the medication (e.g., with meals, etc.)
7. Properly dispose of expired medication samples in accordance with state, federal, and local laws.



## Tip #7: 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 for safely assisting and transferring patients of size.
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 pre-conceived ideas and attitudes regarding weight. Give appropriate feedback to patients to encourage healthful changes in behavior. Encourage patients to set goals and actively participate in their plan of care.
7. Educate the staff about the needs of this patient population to enhance their ability to demonstrate understanding, respect, and sensitivity.





## Tip #8: 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 are documented in the patient's medical record.
2. Medical record documentation of after-hours calls should include the following:
  - Patient's name
  - Name of the caller, if different than 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 complaint
  - 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 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.
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, simple, and include: "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.



## Tip #9: Effective Communication with Patients

**The Risk:** Effective communication is the cornerstone of the doctor-patient relationship. Patients' perceptions of physician communication skills may impact the potential for allegations of malpractice. The following are some suggestions that are designed to promote open communication and enhance your ability to 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 is the highest grade level the patient attained. (<http://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 for communicating with patients who are hearing impaired, deaf, 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
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 will be understandable to the majority of your patient population. Techniques that determine the readability and comprehension levels of documents are available from numerous sources including:
  - <http://www.cms.gov/Outreach-and-education/Outreach/writtenMaterialsToolkit/downloads/toolkitpart07.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.





## Tip #10: 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 failure 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

### 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 causation of the pain; and a focused physical examination to determine if there are objective signs and symptoms of pain. The provider also should review pertinent diagnostic studies, previous interventions and drug history and assess the extent of co-existing medical conditions which 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 upon 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, and the risks of the alternatives, including 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 abuse.
6. Use a written pain management agreement when prescribing controlled substances for patients with chronic pain. If the patient has a prior history of drug abuse, refer the patient 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:
  - Baseline screening of urine/serum medication levels
  - Periodic unannounced urine/serum toxicology screening
  - Medications to be used, including dosage(s) and frequency of refills
  - A requirement that the patient receive medications from only one physician and use only one pharmacy
  - Frequency of office visits
  - Reasons for discontinuance of drug therapy (e.g., violation of agreement)
7. Document and monitor all prescriptions and prescription refills.
8. Consult the New York State Prescription Monitoring Program (I-STOP) registry prior to prescribing any controlled pain medications. Document either that you have consulted the registry, or the circumstances 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 Bureau of Controlled Substances 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 the law firm of Fager Amsler Keller & Schoppmann, LLP to discuss how to discharge the patient and how to handle requests for medications from the patient before the discharge is final.



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

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