Risk Assessment Guideline for Office-Based Physicians and Other Clinicians

| Principle 1 |

The practice should have employment practices to ensure that staff are appropriately trained and supervised, have clearly defined job responsibilities and are periodically evaluated to ensure continuing competence, with follow-up action and training when required. In instances in which you are providing supervision for medical personnel in training (e.g., residents) or collaboration with allied health professionals who are not your employees, roles and responsibilities should be clearly defined.

**Reason we ask this:**

While physicians or other clinicians\(^1\) may delegate patient care tasks or duties to licensed as well as unlicensed personnel, they remain liable for the outcome of these actions. As such, any patient care duty or task delegated to a licensed or unlicensed person must be within the scope of practice, education, training, or experience of the delegating physician or clinician and within the context of a physician-patient relationship. Also, there must be evidence of appropriate training and experience of these individuals to perform the delegated responsibilities. If you are providing supervision for medical personnel in training or allied health professionals whom you do not employ, you can be held vicariously liable for their actions.

**The questions your surveyor will use to evaluate this principle:**

- If you employ staff:
  - Are your employed staff members (including physician assistants [PAs] and/or advanced practice registered nurses [APRNs]) aware of what they can and cannot do? Is this documented?
  - Are your employed staff members evaluated periodically to ensure continuing competence?

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\(^1\) In this context, “clinician” is defined as any individual having direct clinical contact with and responsibility for patients.
Do your employed staff members receive training when required (e.g., annual HIPAA training, when procedures change, when there’s an update to the practice’s EMR, etc.)?

If you supervise staff who are not your employees:

For instances in which you are providing supervision (e.g., personnel in training [e.g., residents], PAs, APRNs or scribes), are these individuals aware of what they can and cannot do? Is this documented?

**Examples of items that might help verify this process:**

- Written job descriptions, state-required practice agreements, such as written collaborative agreements, or written supervisory agreements, practice guidelines for employed staff members

- Copies of license(s) and prescriptive authority for all PAs and/or APRNs as applicable

- Documents verifying training of employees, including initial training and periodic retraining

- Documents verifying HIPAA training within the first 30 days of start date, annually, or whenever there is a significant change

- Documents verifying periodic evaluations for employed staff members

- Documents that outline the roles and responsibilities for supervising medical personnel in training (e.g., residents) and/or allied health professionals (e.g., PAs, APRNs) who are not your employees

**Additional information on the topics covered under this principle can be found here:**
Risk Assessment Guideline for Office-Based Physicians and Other Clinicians

| Principle 2 |

The practice should have a process for noting when patients fail to keep an appointment and a system to ensure that appropriate patient follow-up is documented. The practice should also have a process for ensuring patients who need follow-up treatment make an appointment, and a system to ensure these efforts are documented in the medical record.

*Reason we ask this:*

Angry, too-ill-to-travel, frightened, or nonadherent patients are among those who (sometimes habitually) fail to keep appointments, and they are among those who may require follow-up care, leading to delayed or missed diagnosis. In addition, patients who have recently been discharged from a health care facility often require treatment but may fail to follow up. Monitoring systems that identify these patients and provide a means for appropriate follow-up will assist in preventing patients from “falling through the cracks” and help them get the follow-up care they need.

*The questions your surveyor will use to evaluate this principle:*

- Does a system exist to monitor patients who need a follow-up appointment?
- In instances in which a patient has failed to make an appointment, are attempts to contact the patient documented in the medical record?
- Does a system exist to monitor patients who miss or cancel appointments?
- Are missed and canceled appointments documented in the patient record?
- In instances in which a patient missed or canceled an appointment, are attempts to contact the patient documented in the medical record?

*Examples of items that might help verify this process:*

- Written policies noting how your practice handles:
Risk Assessment Guideline for Office-Based Physicians and Other Clinicians

- Patients who need a follow-up appointment
- Patients who have missed or canceled their appointment

- Appointment books, recall systems, facility tracking logs, discharge summaries
- Medical record documentation showing efforts to follow up with patients who:
  - Were discharged from a health care facility, and required ongoing care
  - Missed or canceled an appointment
  - Did not return for recommended care

*Additional information on the topics covered under this principle can be found here: [http://www.ismiemutual.com/resource-library/appointments](http://www.ismiemutual.com/resource-library/appointments)*

**Principle 3**

The practice should have a process for monitoring all tests ordered to ensure that tests have been performed, and that the test results have been reviewed by the physician or clinician and communicated to the patient. In addition, these efforts should be documented in the medical record, including any efforts made to follow up when results have not been received.

*Reason we ask this:*

Many medical liability lawsuits involve failures within a practice to monitor diagnostic tests and ensure appropriate follow-up of testing. Typical problems include the failure to receive results of tests that were ordered, or the filing of test results without being reviewed by the physician or clinician. Failure to follow up on test results can lead to diagnostic errors, including misdiagnoses, missed diagnosis, and delayed diagnosis. Remember – if you order it, you own it.
The questions your surveyor will use to evaluate this principle:

- Does a system exist to monitor the receipt of test results ordered by the physician or clinician?

- Is there evidence to indicate that the physician or clinician has reviewed the test results?

- Is there evidence in the medical record that test results are communicated to the patient?

- In instances in which a patient has not had a test the physician or clinician ordered, are attempts to contact the patient documented in the medical record?

Examples of items that might help verify this process:

- Written policies regarding how your practice monitors tests, including labs, X-rays, and diagnostic tests

- Monitoring logs, recall systems

- Medical record documentation showing:
  - The physician or clinician reviewed the test results
  - Patients were notified of both normal and abnormal test results
  - Follow-up efforts were made when a recommended test was not completed

Additional information on the topics covered under this principle can be found here: http://www.ismiemutual.com/resource-library/test-monitoring
Principle 4

If a patient is referred to a specialist for diagnosis or treatment, the referring office should have a process for monitoring these referrals, providing necessary clinical information to assist the specialist and ensuring that pertinent clinical information is received from the specialist and incorporated into the treatment plan if necessary.

The specialist practice should ensure that relevant clinical information is provided to the referring physician or clinician.

The referring physician or clinician and the specialist should not rely on the patient to communicate clinical information.

Reason we ask this:

In many situations, a physician or clinician may recommend that a patient seek the services of a specialist—for preventive care not normally provided by that individual, such as a mammogram or colonoscopy, or for a recommended treatment regimen outside the scope of the physician or clinician’s practice. This can also include situations in which a surgeon refers a patient to their primary care physician or clinician for a complete history and physical to obtain clearance for surgery. A failure to follow up on such referrals for consultation or poor communication between physicians and clinicians can result in a delay in diagnosis or failure to diagnose.

Typical problems include:

- A patient fails to make or show up for an appointment with the specialist to which they were referred
- The specialist does not receive appropriate clinical information, including the reason for the referral
- The specialist is unaware of who referred the patient and, as a result, fails to communicate with the referring physician or clinician
Risk Assessment Guideline for Office-Based Physicians and Other Clinicians

- The patient fails to return for follow-up with the referring physician or clinician

The questions your surveyor will use to evaluate this principle:

- Does a system exist to monitor patients who have been referred to a specialist to ensure he or she is evaluated?
- In instances in which a patient has not seen the specialist to whom he or she was referred, are follow-up attempts documented in the medical record?
- Is there evidence that the practice informed the specialist of the clinical reason for the patient’s referral?
- Is there evidence in the medical record to show that the specialist has informed the referring physician or clinician of his or her clinical evaluation?
- Is there evidence in the medical record to indicate that the ordering physician or clinician has reviewed the specialist’s evaluation?

Examples of items that might help verify this process:

- Written policies regarding how referrals are handled
- Written policies regarding how your practice monitors outstanding referrals
- Referral monitoring logs, recall system
- If you refer patients to specialists, medical record documentation that shows you have:
  - Communicated the clinical reasons for making a referral to a specialist
  - Reviewed the specialist’s report
Risk Assessment Guideline for Office-Based Physicians and Other Clinicians

- Made follow-up attempts when patient(s) fail to see specialists
  - *If you receive patient referrals,* medical record documentation that shows you have:
    - Communicated your findings to the referring physician or clinician

*Additional information on the topics covered under this principle can be found here:* [http://www.ismiemutual.com/resource-library/consult-referrals](http://www.ismiemutual.com/resource-library/consult-referrals)

| Principle 5 |

The practice should have a process for providing 24-hour coverage for its patient population. This includes providing coverage when the practice is closed, and for physicians and other clinicians who are sick, on vacation, or have recently left the practice. This process should ensure that relevant patient information is available to the covering physician or clinician, that any relevant after-hours patient contacts are documented and that the information is provided to the appropriate physician or clinician for follow-up when necessary. This process should also ensure that, in the absence of the ordering physician or clinician, all test results are reviewed and acted on in a timely manner.

*Reason we ask this:*

Agreeing to take call or to cover for colleagues is a responsibility accompanied by increased potential for medical professional liability. Having appropriate coverage protocols in place can help prevent liability exposure. This way, if one of those patients calls the covering physician or clinician (who may not have immediate access to the patient's record), he/she will be able to place the patient's complaints in context and take the appropriate next steps.

It is also critical to document all after-hours patient contacts thoroughly, as failing to do so can make care difficult to defend in the event of a lawsuit.

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*“Timely” is defined by the practice's policies and protocols.*
Risk Assessment Guideline for Office-Based Physicians and Other Clinicians

The questions your surveyor will use to evaluate this principle:

- Does the practice have a process to ensure 24-hour coverage?

- Does the practice have a process to ensure relevant clinical information is shared with the covering physician or clinician during handoffs?

- Are patient calls received after-hours monitored to ensure follow-up?

- Is clinically relevant information given/taken while “on-call” documented in the patient’s medical record?

- Is clinically relevant information given/taken while “on-call” provided to the appropriate physician, clinician or other member of the health care team for review and follow-up?

- Does the practice have a process to ensure that, in the absence of the ordering physician or clinician, test results are reviewed and acted on in a timely manner, even if the individual who ordered them is sick, on vacation or has recently left the practice?

Examples of items that might help verify this process:

- Written policy on call coverage and how handoffs are to be accomplished

- After-hours telephone logs from answering service

- Medical record documentation showing a patient who you communicated with after-hours

Additional information on the topics covered under this principle can be found here: http://www.ismiemutual.com/resource-library/coverage
Principle 6

The practice should have a process for handling patient requests—such as medication refills, requests for controlled substances, clinical questions, or requests for referral—to ensure appropriate clinical response. These requests may be received by telephone call or electronic communication, e.g., emails, text messages, faxes, or patient portal messages.

The process should provide clear instructions for addressing requests, including who in the practice is authorized to address these requests and how the requests should be handled. If using electronic communications, efforts should also be made to ensure that these requests are secure and that patient authorization is obtained.

The identity of the person responding to the patient’s request should also be documented in the patient’s medical record. In the event that medication refill requests do not need individual physician or clinician approval, then standard protocols should exist to specify who in the practice can act upon the request, the types of medications allowed, the amount, and frequency of refills allowed.

Reason we ask this:

ISMIE’s claims show a failure to document clinically relevant requests can be a major area of liability. Frequently, patient, physician and/or clinician recollections of information exchanged are not the same. Therefore, a system for monitoring and documenting patient requests is important and should include a process for how they are handled and ensure they are documented in the patient’s medical record.

With ever-changing technology, there are also emergent risks associated with receiving electronic communications from patients that are not triaged appropriately or handled in a timely manner. This can include patients booking online appointments, requests for medication refills, or sending questions to the physicians and clinicians through various technologies such as texts or emails.
The questions your surveyor will use to evaluate this principle:

- Does a process exist to ensure all patient requests are handled in a timely manner, including phone calls, emails, texts, faxes, patient portal messages, etc.?

- Does a process exist to ensure all patient requests receive an appropriate clinical response?

- If using electronic communications, are efforts made to ensure that these requests are secure and that patient authorization is obtained?

- Are clinically relevant calls received during office hours documented in the medical record?

- Are clinically relevant electronic communications (i.e., emails, text messages, faxes, patient portal messages) documented in the medical record?

- Does a process exist for staff to act upon medication refill requests?

- Does a process exist for prescribing and refilling controlled substances?

- Are prescription refills documented in the medical record?

Examples of items that might help verify this process:

- Written policies on how patient telephone calls are to be handled

- Written policies on how electronic communication are to be handled

- Standardized protocols for how prescription refills, including controlled substances, are to be handled

- Job descriptions reflecting delegated prescription authority
Risk Assessment Guideline for Office-Based Physicians and Other Clinicians

- Medical record documentation showing:
  - A patient request, including any follow-up efforts
  - A request for a prescription refill, including any follow-up efforts

Additional information on the topics covered under this principle can be found here: http://www.ismiemutual.com/resource-library/patient-requests

| Principle 7 |

The medical record should include a complete story of a patient’s health care, including documentation of the reason for a visit, a comprehensive medical history, the patient’s presenting complaints, a reconciled medication list, an allergy list, a problem list, physical exam findings, the physician or clinician’s thought process, the plan of treatment, and a plan for follow-up care. Recording, or knowing where to find documentation of, the patient’s or, where appropriate, the family’s treatment preferences (including, but not limited to, DNR orders or advance directives) is an important element as well. Documentation of who has decision-making authority, such as through court documentation of legal guardianship or a power of attorney for health care document, should be clear and up to date. This story should also indicate if other individuals are involved in patient care, such as family members, scribes or interpreters. Lastly, it is important to document the patient’s (and any caregiver’s, if appropriate) understanding when education and instructions are provided, including any informed consent/refusal discussions.

Reason we ask this:

Consider the many purposes of the medical record, including the following:

- Planning the patient’s care, medication and treatment
- Communicating with the health care team
Risk Assessment Guideline for Office-Based Physicians and Other Clinicians

- Conducting peer review and quality assurance activities
- Billing and third-party reimbursement
- Defending medical professional liability claims

The medical record is your way of recording the patient’s health care story—one that another physician or clinician can read and understand when he or she may subsequently need to treat the patient, and one that you can review and recall the next time the patient comes to you. Moreover, many patients are now able to view their records or test results directly via a patient portal. Your patient’s story should have a beginning, a middle, and an ending, and should not require anyone to guess or make assumptions as to the reasons why you decide to take certain actions (such as ordering lab tests), the result of these recommended actions, and the communication of this information to the patient, noting the need for further follow-up when necessary. The reason for an action or conclusion may be important to future patient care; it may also reveal your thought process in the event of a lawsuit.

The questions your surveyor will use to evaluate this principle:

- Do medical records include:
  - a comprehensive and up-to-date medical history?
  - the patient’s reason for the visit and presenting complaints?
  - a reconciled medication list, problem list and allergy list?
  - physical exam findings?
  - a plan of treatment, including any plans for follow-up care?
- When other physicians or clinicians are involved in the patient’s care, is it documented in the medical record?
• When there are surrogates or other decision makers involved in the patient’s care, is it also documented in the medical record?

• Is patient/caregiver education documented in the medical record?

• Do medical records document patient/caregiver understanding of education and instructions provided?

• When treatment necessitates informed consent, such as for a procedure, injection, immunization, or vaccination, is that discussion documented?

• If a patient refuses a specific course of treatment, is that discussion documented?

• Are the patient’s (or family’s, where appropriate) treatment preferences (e.g., DNR orders or advance directives) documented in the medical record?

**Examples of items that might help verify this process include:**

• Examples of clinical summaries that are shared with patients

• Examples of educational materials, including trusted websites, that are utilized in the practice

• Medical record documentation that illustrates a “typical” patient of your practice (whether chronic, long-standing or most commonly seen) and includes the following:
  - initial evaluation that includes complete medical history and physical exam findings
  - presenting complaints
  - plan for treatment
  - patient/caregiver education, including the patient’s understanding
Informed consent discussion

- a discussion of the patient’s treatment preferences, if applicable (e.g., DNR orders or advance directives)
- patient’s (and/or family’s) understanding and agreement with the care plan

Additional information on the topics covered under this principle can be found here:
http://www.ismiemutual.com/resource-library/documentation

Principle 8

Medical records are critical to any defense. They must contain all clinically relevant information, be easy to understand, legible and indicate when and by whom an entry was made. They should also be organized, secured, and corrected properly.

If using an electronic medical record system, it should be backed up periodically. There should also be a plan for accessing and documenting information in the event the EMR is unavailable to ensure the practice can continue to provide critical functions.

Reason we ask this:

Accurate and well-organized medical records are critical to your defense. In the event you are sued for professional liability, your medical records become your most potent legal defense weapon. Poor recordkeeping, whether with paper or electronic records, can force an innocent physician- or clinician-defendant into accepting a costly settlement or verdict that could have been avoided. The importance of good recordkeeping practices to the success of a physician or clinician’s defense efforts in a medical liability suit cannot be overemphasized.

The questions your surveyor will use to evaluate this principle:

- Does the practice have a process to ensure that all clinically relevant information is entered into the medical record in a timely manner?
Risk Assessment Guideline for
Office-Based Physicians and Other Clinicians

- For example, is information on paper scanned into the EMR, are letters sent to patients included in the medical record, etc.?

- Is the information in the medical record organized in a consistent fashion and understandable to others?

- Are you able to determine when and by whom a medical record entry was made?

- Are the medical records secured, including securing all protected health information (PHI)?

- If corrections are made, are you able to determine what was changed, when it was changed, and by whom?

*If using an electronic medical record, we will also ask:*

- Is the EMR regularly backed-up?

- Is there a process to ensure documentation when the EMR is unavailable?

- Are the practice’s technology/security policies regularly reviewed?

**Examples of items that might help verify this process:**

- Demonstration of efforts made to secure medical records and protected health information, e.g., locked file or server rooms, backups, frequency of password changes, automatic logout function, policies on patient portals and electronic communications

- Reports, audit trails, or access logs

- Demonstration of how medical records are corrected or added to properly

- Explanation of process to ensure timely closure of all medical record documentation
Risk Assessment Guideline for Office-Based Physicians and Other Clinicians

- Explanation of process that is followed when EMR is unavailable

- Medical record documentation that illustrates a “typical” patient of your practice (whether chronic, long-standing or most commonly seen) and that is representative of your documentation practices

**Additional information on the topics covered under this principle can be found here:**

### Principle 9

The practice should have a process for assessing their patient’s experience. This should include collecting and reviewing patient feedback (including complaints), sharing feedback with members of the health care team, implementing the appropriate changes, and evaluating whether these changes are having the desired effect. A process should also exist to review adverse events and unintended outcomes, including their impact on the overall patient experience.

**Reason we ask this:**

Assessing how your patients experience you, your staff, and your practice is becoming a necessary component of delivering effective care. This may seem intimidating, but it doesn’t have to be. In fact, you may already be tracking your patients’ experience. Ultimately, you need to ask yourself, *are my patients happy?* And if you suspect—or know—that they aren’t, then you’ll want to ask, *what am I doing about it?*

The non-medical aspects of care (e.g., wait times, payment issues, etc.) can have a significant impact on how and when patients choose to seek care. As a result, understanding how your patients view and experience your practice is vital to ensuring safe and effective care. In addition, studies have shown that many malpractice suits are brought on due to resentment toward members of the health care team, as opposed to dissatisfaction with the actual care provided.
Risk Assessment Guideline for Office-Based Physicians and Other Clinicians

The questions your surveyor will use to evaluate this principle:

- Do you collect patient feedback, including patient complaints?
- Do you regularly review the feedback you receive?
- Are physicians, clinicians and other staff informed of the feedback you receive?
- Are changes ever made based on feedback you receive?
- Do you evaluate whether or not your changes are having the desired effect?
- Does a process exist to review adverse events and unintended outcomes?

Examples of items that might help verify this process:

- Your patient complaint process
- An explanation of how you collect patient feedback, including the use of surveys appropriate to your practice (e.g., a CAHPS survey, MIPS survey data, or a survey you created), the intake of informal comments/feedback, etc.
- A change implemented based on collected feedback
- Information allowing you to determine whether or not an implemented change resulted in the intended outcome
Additional information on the topics covered under this principle can be found here:

- **Patient Experience** – ISMIE course
- **Patient Complaints: Sample Policy** – ISMIE resource
- **Defining the Patient Experience** – The Beryl Institute
- **What is Patient Experience?** – AHRQ
- **Consumer Assessment of Healthcare Providers & Systems (CAHPS)** – CMS
- **CAHPS for MIPS Survey** – CMS

**Please note:** The recommendations contained in this resource are not intended to define conduct that is appropriate in every case, should not be considered as establishing any standard of care, and do not constitute legal advice. Physicians, clinicians and health care providers should take care to ensure that all care rendered reflects the best clinical judgment and complies with the laws and regulations of the state or location at which the care was provided.
Record Pull Worksheet for Office-Based Clinicians

Physician or Clinician’s Name:

- Please complete this worksheet for each physician or clinician being assessed.
- Please pull or identify a medical record for each of the criteria listed below.
- You may use the same patient’s medical record to demonstrate up to three criteria (e.g., Jane Doe’s record for “An after-hours phone call,” “Follow-up efforts to reschedule an appointment” and “A patient who was referred to you for consultation”).
- All records pulled or identified should be of patients who have been seen at least twice over the last year.

<table>
<thead>
<tr>
<th>We need a medical record that shows:</th>
<th>Name and date of birth of the patient who fits this criteria:</th>
<th>Where we can find this information in the patient’s record (date/location):</th>
</tr>
</thead>
<tbody>
<tr>
<td>A discharge from a health care facility, when an office follow-up is required</td>
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<tr>
<td>Follow-up efforts when patient needs, but has not made, a return appointment to the office</td>
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<tr>
<td>Follow-up efforts to reschedule a canceled or missed appointment</td>
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<tr>
<td>Follow-up efforts when a recommended test was not completed</td>
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<tr>
<td>A referral to a specialist was made, but was not completed</td>
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<tr>
<td>A patient who was referred to you for evaluation (e.g., consult, surgical clearance)</td>
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<tr>
<td>An after-hours phone call</td>
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<tr>
<td>Informed consent/refusal discussion (a procedure, injection, immunization or vaccination)</td>
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<td></td>
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<tr>
<td>A patient for whom you are prescribing opioids</td>
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</tbody>
</table>