COPIC®

Better Medicine • Better Lives

RISK MANAGEMENT 101:

Essential Guidelines to Help Improve Your Medical Practice

October 2023

COPIC believes that the best medical professional liability coverage not only provides support when you face a claim or lawsuit, but also helps you prevent unexpected and adverse incidents from occurring in the first place.

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Information provided is for general education purposes and not intended as legal guidance or practice standards.

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A FOCUS ON PATIENT SAFETY AND RISK MANAGEMENT

COPIC takes an industry-leading approach toward patient safety and risk management by investing in programs with proven results, developing educational activities, and providing access to medical and legal staff who offer expert guidance.

This booklet is an introduction to the core risk management principles that are used to establish guidance and support. COPIC draws upon our expertise to teach practical, pragmatic techniques for reducing risk and improving outcomes.

All of COPIC's patient safety and risk management resources are included in your coverage at no additional cost.

Timely Reporting Allows Us to Provide the Best Support

Contact COPIC promptly after any major unexpected outcome or incident that could adversely affect a patient's care.

- Promptly notifying COPIC of an incident allows us to consider all possible approaches for the best response and resolution.
- Early reporting enables us to capture details while an incident is fresh in everyone's minds.
- It also allows us to evaluate whether a situation is appropriate for COPIC's 3Rs Program or the Candor process in Colorado, Iowa, Minnesota, and Utah which seek to maintain the physician-patient relationship and resolve matters after an adverse outcome.
- Reporting an incident also serves as a trigger to help determine if and how your insurance coverage may apply.

If in doubt, always report.
There is no penalty for reporting an incident.

THE REPORTING PROCESS

1. Ideally, the **provider involved should report the incident**—some systems may have specially trained risk managers to assist in reporting.
2. Make every effort to **report within a reasonable time** (within 24 to 72 hours) after the provider or practice becomes aware of the incident.
3. **To report an incident, call (720) 858-6395 during business hours (M–F, 8am–5pm, Mountain Time).** Written and/or emailed reports may be "discoverable" information that would become available to an opposing attorney.
4. **Outside of business hours, you can initiate the reporting process on our website and we will follow up with a call.** To submit an online incident report, log in to the Service Center and select "Incident Reporting."
5. **Have the following information ready**: patient identification* and type of insurance they have (if any), policy number, date(s) of service or incident, and procedure/medical services provided.

**Please note that you do not need to obtain a patient's consent—written or otherwise—to share HIPAA Protected Health Information (PHI) with COPIC in an incident report.*

SYSTEMS AND PROCESSES

ENSURE THAT STANDARDIZED SYSTEMS ARE IN PLACE FOR THE FOLLOWING:

- **Patient follow-up**—Alerts a practice as to who must return to the office or is referred to another provider, and by what date this should occur.
- **Test tracking**—Identifies all "essential" diagnostic tests ordered (either done within or outside the office) and alerts the office to missing reports in a timely fashion.
- **Reviewing and acknowledging all reports and correspondence**—Reinforces that nothing gets missed, prior to closing the file.
- **Notification of test results**—Tracks that patients are properly informed of test results.

UNDERSTAND THE PURPOSE OF INFORMED CONSENT

- The **informed consent process** is obtaining consent by a discussion of the indications for, risks and benefits of a particular procedure or treatment, risks of alternatives including doing nothing, and any specific risks for a particular patient. This should be documented in the medical record.
- An **informed consent form** is used to document the informed consent process. The presence of a form does not release the provider from the duty of obtaining consent. It should be completed by the provider and the patient with signatures memorializing that the patient understands the risks and benefits. COPIC has a variety of downloadable consent forms at www.callcopic.com.
- Others may assist in the informed consent process, but **the provider performing the procedure or providing the treatment must have the final discussion with the patient to answer questions and ensure understanding.**
- **Informed refusal** occurs when a patient refuses a recommended medical treatment based upon an understanding of the facts needed to make a decision. The patient's refusal should be documented in the medical record. High-risk scenarios may indicate the need for a signed informed refusal form memorializing the discussion. COPIC has developed an informed refusal document that can be found on our website at www.callcopic.com/resource-center/guidelines-tools/consent-forms. (Login is necessary.)

MAINTAIN THE REQUIRED OVERSIGHT OF ALLIED HEALTH PROFESSIONALS/ADVANCED PRACTICE PROVIDERS (AHPs/APPs)

Compliance rules for supervising AHPs/APPs vary across different states and by role. **Providers should be familiar with and understand the requirements for their particular state.** Common questions outlined in regulations include:

- What services are AHPs/APPs allowed to perform independently and which ones require direct supervision?
- What are the supervisory requirements and who is designated as the supervising physician?
- What qualifications need to be reviewed and how often?
- What documentation or agreements need to be in place and how often do these need to be updated?

MEDICAL RECORDS

THOROUGHLY DOCUMENT PATIENT COMMUNICATION IN THE MEDICAL RECORD

Comprehensive and concise documentation provides for safe continuum of patient care, reflects clinical decision-making, and supports action taken.

1

All communication with patients should be documented when one of the following occurs:

- Prescribing or changing medication
- Making a diagnosis
- Directing treatment
- Directing patient to another provider or facility

2

Documentation of communication should include the following:

- Patient's name
- Names of people accompanying the patient during a visit or calling regarding a patient's care, and their relationship to the patient
- Date and time
- Date of birth
- Reason for the visit/call, including a description of the complaint or symptoms
- Medical advice or information provided
- An assessment of allergies and other adverse drug reactions if a medication is prescribed

ENSURE DOCUMENTATION IS ACCURATE AND READABLE

Providers should authenticate that what is written in a progress note is accurate, clear, and meaningful for that patient's visit, prior to sign off. This includes:

- Clear identification of the patient and authorship in all documentation.
- A thoughtful review and analysis of the patient's progress; include differential impressions as well as a narrative of the next steps in the plan of care.
- Clear annotations, date amendments, and record corrections.

PATIENT DETAILS THAT SHOULD BE INCLUDED IN THE MEDICAL RECORD

- An up-to-date list of allergies and adverse drug reactions.
- A current, standardized problem list or similar summary device to help avoid overlooking important information about a patient's medical issues.
- A current list of medications the patient is taking.
- Accurate, documented vital signs, particularly in acute illnesses.

BEST PRACTICES FOR DOCUMENTATION

- Confirm that items generated from lists, checkboxes, etc. are what was intended
- Be familiar with the content of any templates you use
- Double check results of drop-downs, templates, auto-complete, etc.
- Be judicious when using "copy" and/or "paste" and carefully edit and remove irrelevant or unintended content
- Have a way to incorporate relevant email and text messages into the EHR
- Record facts in an objective manner; avoid needless commentary
- Minimize use of abbreviations and have an approved list of abbreviations
- Correct errors in the record in a way that makes evident who made the change and when
- Review all providers' progress notes and all staff notes
- Recheck decimal points
- Document discharge instructions
- If using a scribe or a virtual scribe or equivalent service to prepare the note, review the note for accuracy, edit it, and provide a statement that you have done so.
- Comply with the 21st Century CURES Act Information Blocking Rule to enhance patients' access to their records and for the exchange of health care information.

THINGS TO AVOID WITH DOCUMENTATION

- Clone notes
- Import content without reviewing it
- Let automatic "copy/paste" become a regular component of your system
- Select "something close to the right choice" from a list, if the correct choice is not available
- Chart non-medical information (e.g., call to COPIC, attorney, peer review activity, incidents)
- Criticize other medical personnel
- Edit, delete, or modify documents if you receive a record request or subpoena
- Avoid "Information Blocking" which is defined under the CURES Act as any practice that is likely to interfere with, prevent, materially discourage, or otherwise inhibit the access, exchange, or use of Electronic Health Information.

All devices that contain PHI or by which PHI can be accessed (those in the office or those leaving the office) should be password protected and encrypted at all times to assure no unauthorized access.

MEDICAL RECORDS

HIPAA—Releasing medical records

Under HIPAA, patients have the right to review (free of charge) and receive a copy (for a reasonable, cost-based fee) of their medical and billing records and any other records that are used to make decisions about a patient. Failure to comply with HIPAA's access requirements has been one of the top five most common violations of HIPAA.

HIPAA allows you to provide copies of another provider's records that are contained in your records.

A provider may require a patient to submit any request for access to records in writing, but only if the patient has been informed of this requirement, usually in the Notice of Privacy Practices.

In general, health care professionals are required to provide the records in a "timely" manner (as soon as reasonably possible, but no later than 30 days after the request).

The Privacy Rule requires physicians and other health care providers to produce the records in the form and format requested by the patient, if readily producible in that form and format, or if not, in a readable hard copy form.

The provider can charge a reasonable, cost-based fee for providing a copy, but can only charge for the following:

- The cost of labor for actual copying time. Time spent reviewing the request, retrieving the records, etc. cannot be charged;
- The cost of supplies (e.g., paper and toner, or USB drive or DVD, if electronic); and
- Postage if the patient requests the records be mailed.

Best practices—electronic health records (EHRs)

- Every person who has access to the EHR should have his or her own individual password that should not be shared with others.
- Employees should always lock the computer before leaving the terminal for any reason and computer terminals should automatically lock after a specified time of inactivity.
- An "audit trail" feature—which records who accessed your information, what changes were made and when—should be in place and turned on.
- EHR system data must be backed up regularly—daily, weekly, incremental, or full.
- Stored data should be routinely tested to validate backed-up data integrity.
- When prescribing medications, the EHR system should actively alert providers to drug/drug interactions at the time the medication is being prescribed.
- Providers should keep current on issues and trends involving electronic health records to remain knowledgeable of inherent risks.

Legal Helpline

Our Legal Helpline can support your legal, non-clinical matters, such as EMTALA, HIPAA, grievances, and other complex health care topics. Call us during business hours at (720) 858-6030 or email LegalHL@copic.com.

COMMUNICATION WITH PATIENTS

Key guidelines for effective communication with patients:

- Ask patients to explain the reason for their visit.
- Avoid distractions and physical barriers between you and the patient.
- Take the time to determine the patient's expectations and desired outcome.
- Involve the patient to the fullest extent possible in care and treatment decisions.
- Close the communication loop, summarizing and/or asking for teach-backs.

DEALING WITH NONADHERENT PATIENTS

Having frank discussions with patients and being non-judgmental can be an effective way to find out more about the patient's perspective and reason for nonadherence.

- Ask your questions in an open manner using active listening techniques and explore the reasoning behind a patient's nonadherence.
- Patients are also likely to react more positively to treatment if they are involved in core decisions and if they understand that the advice given by their health care provider is personal, and not a one-size-fits-all.
- Patients should be made aware of resources available to help them implement and follow proposed treatment plans.
- When it comes to prescribed medications, affordability can be a factor in nonadherence. Physicians should diplomatically ask patients if this might be an issue and can propose less expensive, but effective, alternatives.
- Side effects may also concern patients, and physicians should discuss the possibilities beforehand so patients understand what action might need to be taken.
- If you have a discussion exploring the reasons for nonadherence, include these reasons and what you talked about in the medical record.

TERMINATING A PROVIDER-PATIENT RELATIONSHIP

Because the provider-patient relationship is voluntary for both parties, either side can terminate the relationship. However, be aware that the issue that led to termination could trigger the initiation of a medical liability, disciplinary or other action. Issues to consider before termination include:

- **Abandonment**: Unless certain conditions are addressed, allegations of abandonment may be made if a physician terminates care during the treatment of a medical condition. The patient must be in stable condition. You must give adequate notice, provide emergency medical care for a specified period, and assist with the continuity of care by expeditiously providing the patient's new physician with copies of medical records when requested. It is recommended that the emergency care period be 30 days. However, it may be necessary for this to be longer in certain clinical situations due to ongoing medical care issues and the availability of other medical resources.
- **Discrimination**: You should be aware that termination may not be based upon gender, race, religion, disability, ethnic origin, national origin, or age. Disability status can be complex and contentious. Further, local laws might protect against discrimination based on issues such as sexual orientation.

- **Contract issues**: Be cautious when terminating patients who are members of managed care plans. Your contracts with health plans might specify the manner of termination with a member patient. This is especially true if the method of payment is capitation. Plans might need notification of the reason for termination to prevent allegations of dismissing a patient because he or she is "too expensive to treat." The patient might also have different time constraints for the health plan to complete reassignment to a new physician. Medicaid has a specific process for termination of Medicaid patients, and health care professionals need to consult their provider participation agreement for details.

WRITING A TERMINATION LETTER

All terminations should be documented in writing so that the patient understands the need to find another health care provider. A termination letter should:

- Be succinct.
- Spell out that emergency care will be provided for a period of 30 days or as required under a Medicaid or other health plan contract.
- State that a new provider should be sought and suggest that the medical society and/or the patient's health insurance might assist them in finding a new physician or health care provider.
- Make sure your office staff knows of your plans. The patient should be reappointed to see you only if there is an emergency medical condition.
- Assure the patient that all medical records will be provided at his or her request.
- Avoid editorializing or restating your side of a dispute in the termination letter. A simple "It has been determined that I can no longer function as your physician" is adequate. The documentation in the medical record can be more detailed, but should remain factual and avoid pejorative or emotional statements regarding the termination.
- Send the letter via certified U.S. mail. For specific clinical situations (i.e., the need to follow up on a critical lab/image or to complete a procedure or consultation) the letter can include the reasons for the necessary actions and the risks of not complying with them.

COMMUNICATION WITH OTHER PROVIDERS

USE A PATIENT IDENTIFIER

To help ensure the right care for the right patient, it is recommended that in addition to the patient's name, an additional identifier be used in all verbal and written correspondence (e.g., date of birth, middle initial, or address).

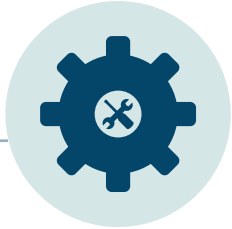
TAKE THE PROPER STEPS TO ENSURE EFFECTIVE PATIENT HANDOFFS

- The patient hand-off should not be viewed merely as an exchange of information, but should include information such as how the patient's status is or is not consistent with what is expected. The degree to which the information is discussed will depend on the individual patient and situation, but certain broad areas should always be covered such as:
  - Baseline benchmarks
  - Expectations (to include responsibility for care—who is to do what next; be sure to name names rather than using pronouns)
  - Most recent phase of care
  - Current status

ALWAYS PERFORM READ-BACKS OF VERBAL ORDERS

- Verifying written or verbal orders for accuracy ensures that the "right patient, right medication, right dose, right route, and right frequency" occur, whether in the office, the pharmacy, or the hospital.
- Whenever possible, medical orders and reports of critical test results should be in writing because orders and test results given verbally or over the telephone have a high potential for error.
- Critical test results often must be reported by the most direct form of communication that ensures the information is received and will be acted on; often that is via telephone, but could be closed loop communication within an EHR. However, steps can be taken prior to implementing the orders or acting on critical test results to reduce errors, including the following:
  - The receiver should write down the critical information, orders or test results (or enter them into a computer) as they are being given and read back for accuracy (then placed in the chart).
  - Additional information, such as the patient's response or plan, should be documented and placed in the chart as soon as possible.

COPIC RESOURCES*



EDUCATION RESOURCES

How do you stay informed on prominent issues such as prescribing opioids, regulations with electronic communication, and managing allied health professionals/ advanced practice providers?

- COPIC's in-person and virtual seminars and on-demand courses cover timely topics; we also work with insureds to offer customized seminars.
- COPIC has accreditation from the Accreditation Council for Continuing Medical Education (ACCME); certain activities also qualify for CME credit. COPIC is also accredited as a provider of Continuing Nursing Education (CNE).
- Visit **www.callcopic.com/education** to view a current list of our educational activities.

3Rs PROGRAM/CANDOR PROCESS

Unexpected outcomes happen. Do you know who to call for expert advice on disclosing an incident with a patient?

- COPIC's 3Rs Program, and the Candor process in Colorado, Iowa, Minnesota, and Utah focus on handling unexpected outcomes in ways that facilitate open communication, preserve the provider-patient relationship, and address the patient's needs.
- 3Rs is designed as an alternative approach to litigation and recognized as a benchmark communication and resolution program by the *New England Journal of Medicine* and *Health Affairs*.

SAFETY AND RISK STRATEGIES

Medical processes and systems are complex, and require assessments to avoid unforeseen risks in areas such as test tracking, EHR documentation, and managing allied health professionals/advanced practice providers.

- COPIC's reviews are overseen by nurse specialists who conduct an independent evaluation of your processes and systems.
- Self Assessment tools are available for eligible insureds and are also reviewed with nurse specialists.
- The focus is on identifying high-risk areas, developing a customized plan to address these, and implementing best practices.

24/7 RISK MANAGEMENT HOTLINE AND LEGAL HELPLINE

Medicine doesn't adhere to a 9-to-5 schedule. Who would you call if you needed immediate guidance on dealing with a difficult patient?

- COPIC's 24/7 risk management hotline is staffed by physicians who are available to answer your questions and help you resolve issues.
- The hotline can be reached at (866) 274-7511.
- Our Legal Helpline can support your legal, non-clinical matters, such as EMTALA, HIPAA, grievances, and other complex health care topics. Call us during business hours at (720) 858-6030 or email LegalHL@copic.com.

COPISCOPE NEWSLETTER AND SPECIALTY PUBLICATIONS

Learning from past medical errors is essential to preventing future ones. That's why we share our insight and knowledge through our newsletter and other resources.

- Articles written by physician risk managers and legal experts offer practical guidance to improve your practice.
- Specialty publications include "*Minors and Risk: Frequent Liability Concerns in the Health Care Setting*," "*Law Enforcement Interactions*," and *"COPIC Insight: Navigating the Medical Liability Aspects of Telehealth"* booklets.

ONLINE RESOURCE CENTER

COPIC has created an online resource center that provides access to valuable resources and tools.

- Clinical guidelines and medical records forms
- Sample consent forms and HIPAA forms that you can download and use
- Practice management resources that offer guidance on common issues
- Candor resources for Colorado, Iowa, Minnesota, and Utah

**State regulations and legal environments may limit the scope or availability of certain programs/resources. Please contact COPIC for details about your specific state.*

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