

Risk Management 101: *The Bare Essentials*

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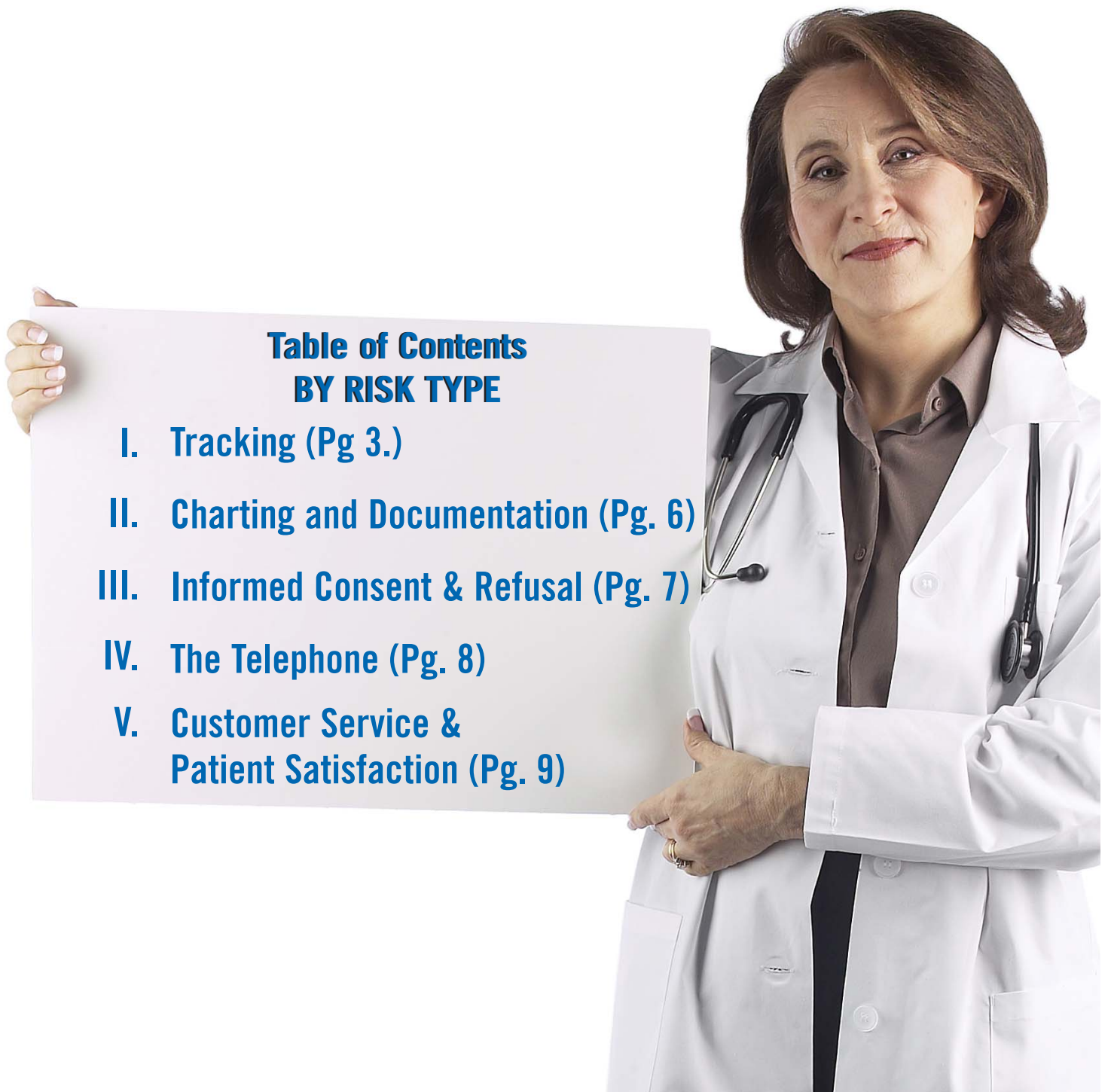
Disclaimer

All documents provided in this program are samples only and may not address the unique needs of every practice. MAG Mutual recommends that legal counsel be consulted to ensure that all forms and procedures are tailored to meet the specific needs of individual practices and comply with specific legal requirements.

Objectives

The objectives of this program are to:

- Outline the major medicolegal risks that small practices face.
- Offer concise, practical recommendations to address these risks.
- Provide links to useful sample forms and additional information.



Introduction

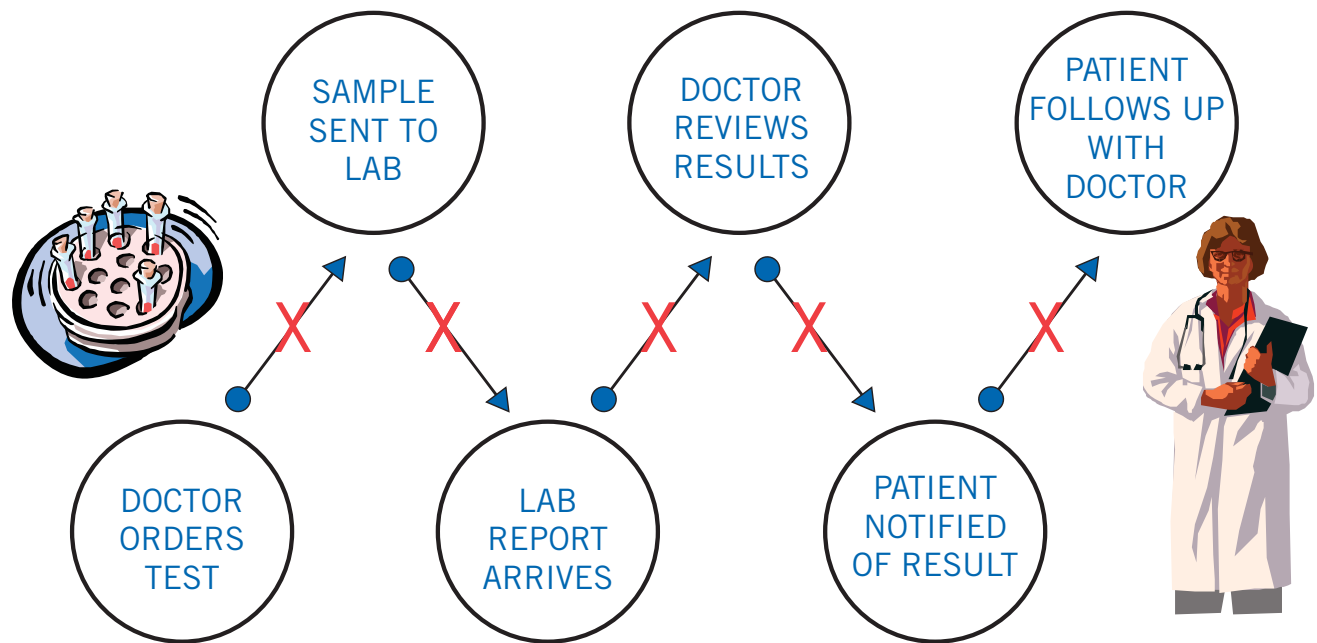
A physician in today's small practice faces extraordinary challenges. To be successful, a practice must be decisively led, well managed and properly staffed, on top of being clinically up to date. A small practice doctor must often wear numerous unexpected hats. Human resources, accounting and quality control all have to be mastered, and all of this occurs against the backdrop of serious medicolegal risk.

We at MAG Mutual appreciate the challenges of our small practice policyholders. In fact, we've designed "Risk Management 101: The Bare Essentials", specifically to address their unique issues. Our aim is to teach effective risk management methods in a concise way, thereby yielding immediate practical patient care and error reduction benefits.

This program is meant to be completed in 30 minutes (or an hour, including the CME posttest). It is organized in five brief sections by major risk type. Specific risk types are detailed individually, including a short description, recommendation and (for most risks) a link to relevant sample forms. The entire program consists of just ten pages.

We invite all policyholders, but especially our small practice physicians, to learn from this program.

(A) Diagnostic Tests



Diagnostic Test Workflow

This illustration maps out the diagnostic test process. Failure of the process because of an inadequate tracking system (or no system at all) continues to cause numerous bad outcomes. Small practices are especially susceptible because so many are unaware that a risk even exists.

Fortunately, these outcomes are largely preventable with an effective system. To be reliable, the process must ensure that information consistently flows from point to point along the continuum, regardless of the circumstances.

The red Xs mark points at which system failures have occurred. Moving from left to right, they represent: a patient's failure to have a blood sample drawn, the lab's failure to send the doctor a copy of the report, the practice's failure to forward the report to the doctor (perhaps due to misfiling), the practice's failure to notify the patient of their result, and the patient's failure to return to the practice for further treatment in light of the result.

Disastrous outcomes have resulted from system breakdowns all along the diagnostic test continuum. It is clear that creating a simple, reliable system that anticipates errors and 'closes the information loop' is crucial to preventing these outcomes.

[CLICK HERE FOR A SAMPLE DIAGNOSTIC TEST TRACKING LOG FORM](#)

I. TRACKING

(B) Missed, Cancelled and Rescheduled Appointments



“Scheduling is the patient’s responsibility”, the long chanted mantra of many physicians, simply isn’t true. Terrible outcomes have resulted where patients have missed, cancelled or rescheduled their appointments. The cause and effect are always the same: the patient was not seen in time to render a proper diagnosis and treatment.

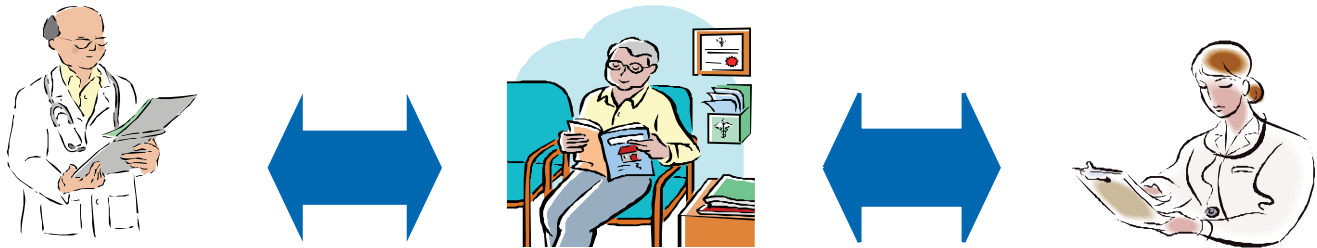
Practices often try to avoid responsibility for these outcomes by declaring that it is the patient’s obligation to schedule and show up for their appointments. They argue that whatever results from a patient’s failure to come in (like delayed diagnoses or treatment) rests squarely on the patient’s shoulders. Small practices support this position with even greater conviction because they deem follow-up to be a dispensable function.

Unfortunately, most juries see the matter differently. In their view, the doctor (who better understands the consequences) is duty-bound to affirmatively guide the patient, particularly where their conduct might endanger them or thwart their recovery. A tracking system acknowledges this reality.

An effective tracking system is the solution. As with diagnostic test result failures, establishing and maintaining a tracking system usually prevents errors. An effective missed, cancelled and rescheduled appointment tracking process should identify patients, confirm the seriousness of their conditions and allow for the rescheduling of their appointments.

[CLICK HERE FOR A SAMPLE CANCELLATION/NO SHOW LOG FORM](#)

(C) Referrals & Consultations



A referred patient can easily be caught in the middle.

“I’m only referring as a courtesy, since I’m treating a different body part.” Physicians often refer patients to a doctor of another specialty, where they discover a condition that is beyond the scope of their practice or outside their specialty, but want their findings to be properly followed-up upon. While many doctors believe that their referrals are purely gratuitous, they’re actually far more.

When a doctor seeks a referral or consultation on a patient’s behalf, they are effectively saying, “I have a concern or hunch about these findings and I’d like you to take a look, just to be sure.” The fact is, once they refer or consult a patient out, they have taken on an obligation: to proactively and assertively guide the patient to the best possible medical outcome.

Is a referring doctor responsible for ensuring that the patient actually follows through on their referral? Of course not. Adult patients are expected to be responsible for themselves. However, the reality is that some patients will not follow through, progress to a bad outcome, then attempt to attribute the failure to their treating physician. More than a few juries have been persuaded by this argument, especially where a patient’s serious condition generated a lot of sympathy.

The wise physician who refers anticipates this scenario and appreciates its implications. First, they know they are duty bound to make the referral in the first place, since they must respond to information that a similarly situated doctor would regard as being significant.

Second, they understand that if a patient fails to act on their referral and the scale of risk is high, then the doctor should make reasonable efforts to notify them of the potential consequences. Then, should a bad outcome result, the patient would be hard pressed to suggest that the doctor had ‘dropped the ball’. A referral/consultation tracking system is the solution. It enables the referring doctor to reconcile a referral out of the practice with the patient’s actual follow-up.

II. CHARTING & DOCUMENTATION



A solid medical record is the cornerstone of patient care and medicolegal defense. Thus complete charting is key. What are the most important issues to document? A basic list would ask whether you:

- **Update** problem, medication and allergy lists at every visit. Without this essential information, it's difficult if not impossible to properly diagnose and treat a patient.
- **Maintain** visit **notes** in a **standard** format, like SOAP. If the members of a practice all chart differently, then the risk of overlooking an important point rises sharply.
- **Include** articulated treatment **rationales** in your notes. If you only include diagnoses and prescriptions or other proposed treatments, but nothing to link your conclusions to the findings, (like a reference to a guideline or other published literature) then it becomes much more difficult to defend your medical judgment, if it's ever disputed.
- **Document** the handout of **sample medications**. These involve the same duties as any other drug, namely to document prescriptions and to consider potential interactions, allergies and ease of administration. Written instructions should also be provided.
- **Promptly dictate** visit notes (if you dictate at all) and review the transcription right away. We recommend dictating within 24 hours of a patient encounter, and reviewing and signing the transcribed notes within 72 hours of your receipt. Once these time limits pass, the likelihood of creating a complete and accurate record drops dramatically.
- Consistently **follow** a solid **record release policy**. It should include a designated release reviewer, a provision for physician authorization, and reviews for scope of authority, privileged content and HIPAA compliance.

An effective chart is imperative for excellent patient care and, in case of a claim, indispensable for a successful defense.

[CLICK HERE FOR A SAMPLE CHART AUDIT FORM.](#)

III. INFORMED CONSENT & REFUSAL



“If I had only known, I never would’ve agreed to the treatment.”

After an unexpected bad outcome, patients often claim that they never fully understood the nature of the treatment they undertook. Informed consent (and refusal, where patients opt against a proposed treatment) are, of course, absolutely essential for excellent patient care and to reduce medicolegal risk.

In terms of patient care, better educated patients tend to be more actively involved in their treatment and, in turn, more compliant. Where a bad outcome occurs, they are typically better emotionally prepared by their greater awareness. From a risk management perspective, an effective informed consent process and good documentation clearly evidence the patient’s knowledgeable and mindful consent to the treatment.

Forms, forms and more forms. Remember, the goal of informed consent is not merely to get the patient to scrawl their signature on a form. Nor is it to produce as much defensive paper as possible. The true objective is to effectively communicate the details of a proposed treatment with the patient (and their family or support person), and to document that communication.

How do you rank on informed consent? Do you:

- Use procedure-specific forms? These forms outline the unique risks and benefits of a specific treatment or therapy.
- Use informed refusal forms? These document a patient’s decision to forego a proposed treatment.
- Routinely document the handout of patient education materials? Giving out literature reinforces the informed consent process; documenting the handout confirms that the handout actually occurred.
- Follow a sound consent process? Specifically, that means a knowledgeable staff member fully discussed the proposed treatment or therapy with the patient. In addition, enough time is allowed for the discussion and it is held in a conducive environment.

Informed consent is usually legally required. Properly obtained, however, it’s also an invaluable aid to promoting excellent patient care. Savvy practices recognize this important opportunity to actively engage patients in their care.

[CLICK HERE FOR A SAMPLE INFORMED REFUSAL FORM.](#)

IV. THE TELEPHONE



Telephone Triaging

As every doctor knows, rendering medical advice by phone presents unique problems. First, a patient can't actually be observed to ascertain their condition. Second, there is often no chart available to review. Physicians and clinical staff are thereby left at a big disadvantage when they render advice by phone.

On the risk management front, two issues stand out. First, well-intended but inadequately trained staff members have incorrectly advised patients, and some disastrous outcomes have resulted. Second, calls concerning patient care are sometimes not documented, which has led to gaps in the continuity of care.

Effective risk management can prevent many of these outcomes. A written clinical telephone protocol will curtail improper advice. A strong policy to document all calls concerning patient care will ensure continuity of care, as well as a complete record.

[CLICK HERE FOR A SAMPLE TELEPHONE MESSAGE FORM.](#)

V. CUSTOMER SERVICE & PATIENT SATISFACTION



Outstanding service is key for excellent care.

As a business that operates in a competitive industry, a medical practice must anticipate and fulfill patient needs. The point is doubly important in these litigious times, since perceived lackluster service often leads to frustration and, finally, desperation. Desperation arises when patients reach the conclusion that the practice either doesn't care about them or simply isn't standing accountable for its care. At that point, disgruntled patients typically conclude that they have no other recourse and nothing to lose by suing.

Every service business, no matter how well run, encounters customer issues from time to time; medical practices are no exception. The key is to prevent patient frustration (or at least escalated frustration) by anticipating these episodes, setting up systems to capture the issues, tracking each through to resolution and, at reasonable intervals, evaluating the data for discernible patterns and improvement opportunities.

In practical terms, that means having an established patient complaint process (preferably formally sketched out in a written policy), using a standard patient complaint form (that's completed by either the patient or a staff member), maintaining a separate complaint filing system (because the medical record is not the proper place to keep patient complaints), and periodically tracking and trending the results.

Once an effective complaint management system is in place, more 'big picture' thinking becomes possible. At that point, patient satisfaction surveys and flow studies are invaluable tools to further improve service and care delivery quality.

[CLICK HERE FOR A SAMPLE PATIENT COMPLAINT FORM.](#)

[CLICK HERE FOR A SAMPLE TIME FLOW STUDY WORKSHEET.](#)