PHYSICIANS INSURANCE

SELF RISK ASSESSMENT (OUTPATIENT SETTING)

QUESTION	TIPS FOR BEST PRACTICE	SUPPORTING RESOURCE
CARE TRACKING SYSTEMS		**VISIT THE RESOURCE LIBRARY AND SEARCH FOR:**
Is there an appointment recall system for follow up on patients who require ongoing monitoring for their medical conditions?	Some medical conditions require regular monitoring to ensure that a safe and appropriate level of care is provided. Consider using evidence-based algorithms and/or practice guidelines to implement a mechanism that tracks the medical conditions requiring necessary follow-up. Assign this responsibility to ensure oversight and accountability for follow-up.	"Patient Reminder and Recall Interventions for Cancer Screenings"
Is there a process in place for timely reconciling diagnostic tests ordered and received?	A well-defined written and standardized process should be in place to ensure timely receipt of test results. Monitoring should be assigned to a responsible staff member who is also accountable for follow-up should there be a delay in receipt of results. A delay in diagnosis and/or treatment may result in the absence of tracking. Oversight and monitoring can reduce delays.	"Closing the Loop on Tests and Referrals"
Is there a process in place for tracking patient referrals to a consulting specialist when a patient does not follow through or when there is a delay in receiving the consultant's report?	Establish a written process to track all referral consultations with specialists. The process should include the assignment of tracking to a staff member who will monitor and be responsible for follow-up with the patient and/or specialist when a report is not received as expected. A delay in diagnosis and/or treatment may result in the absence of tracking referrals. Oversight and monitoring can reduce delays. Do not rely on the patient to inform the practice of a delay in follow through.	"Closing the Loop on Tests and Referrals"
COMMUNICATION		
Are there triage protocols in place for use during normal business hours?	Patient triage protocols provide standardized guidance for clinical staff to appropriately assess patients contacting the provider for medical advice. Use of protocols can assist with patient disposition, avoiding delays when more immediate attention is required.	

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Are patient requests for medical advice or urgent appointments forwarded to clinical staff or a provider?	Unlicensed office personnel should not provide medical advice. Doing so would exceed the scope of practice for the non-clinical staff. This can lead to malpractice risk through a missed diagnosis and/or a delay in treatment.	
Is a mechanism such as a "chain of command" policy used to resolve patient safety issues by allowing clinical staff to present a concern through the lines of authority?	When patient care or safety issues are identified, guidelines should be in place empowering staff to elevate issues, without concern of repercussions, until a resolution is reached. This not only protects patients; it also builds trust and enhances the organization's culture of safety.	"Chain of Command in the Outpatient Setting"
Is a qualified healthcare interpreter available for verbal communication when a patient presents with English as a Second Language (ESL) or is in need of communication via American Sign Language (ASL)?	To prevent miscommunication of vital information, qualified healthcare interpreters should be used to translate information related to the patient's care. The patient's family or medical office staff should not be used as interpreters unless there is an emergency in which the patient is at risk for imminent harm. The name of the qualified healthcare interpreter should be documented in the medical record.	"Communication and the Use of Interpreter Services"
CONSENT PROCESS		
Are the key elements of informed consent, including risks, benefits, alternatives, and common complications documented on a consent form or in the patient's medical record?	Documentation should include the key elements of the informed consent discussion. One way to efficiently achieve this is to use a consent form. If a form is used, it should allow for the signatures of the provider and patient/representative and include the date and time it was signed. Use of a signed form further validates communication exchange with the patient/representative and remains one of the most important patient safety/risk management tools providers have.	"Informed Consent and Refusal Resource Guide", "Informed Consent Sample Form"
Is a form which includes the consequences of declining care and the patient's signature utilized for instances when care is declined?	Informed refusal is a process in which the provider discloses essential information to ensure that the patient is well informed to refuse recommendations for diagnostics, referrals, procedures, and/or treatment. A process should be developed to address a patient's decision when declining care. The process should include the use of a form signed by the patient and include possible risks to health and their reasons for declining care.	"Patient Declines Recommended Medical Procedure or Treatment", "Patient Declines Recommended Medication"

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Is there a written policy as defined by state law in place allowing a minor, in the absence of an adult, to consent to care?	In most states, the law defines when a minor, in the absence of an adult, can consent to treatment. When a minor presents for care, whether alone or in the presence of a parent or legal guardian, state law should be followed. This allows the minor to consent to treatment, as well as to the release of medical records associated with the episodes of care. Additionally, the minor should be advised that use of a parental insurance carrier to cover treatment may result in inadvertently notifying the parent of care provided.	"Informed Consent and Refusal Resource Guide"- Informed Consent by Minors
MANAGEMENT OF HEALTH INFORMATION		
Is there a policy in place to address a time frame for documentation after a patient encounter?	Documentation of a patient encounter should be completed during the visit, immediately concluding the encounter, or at the latest by the end of the day. Delays in documentation may result in the absence of pertinent details being recalled, and therefore not reflected in the record.	"General Medical Record Documentation Guidelines"
Is there a policy and procedure in place including guidelines for the general release of protected health information, the release of protected health information for minors, and the release of sensitive health entries, such as sexually transmitted infections, mental health, and/or substances use and abuse?	It is the obligation of the practice to follow state and federal guidelines for the release of medical information. When a policy and procedure are in place, steps can be implemented to safeguard against inappropriate release of protected health information. The policy should address particularly sensitive situations that may require additional safeguards for unauthorized release.	"Federal Authorization to Use or Disclose Protected Health Information- Policy & Procedure"
If an electronic health record or practice management system is in place, is there a process to address documentation when the system becomes unavailable?	Planned and unplanned events may result in the electronic health record and other practice management systems being unavailable during normal business hours. Alternate documentation practices should be established for recording patient activity during an encounter. The alternate documentation should be incorporated into the appropriate system when capabilities are restored.	"Data Loss: Strategies for Managing Medical Documentation After a Cybersecurity Incident"

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Do you have a defined process for clinicians to authenticate their medical records when using Artificial Intelligence in patient care, including outsourced or vendor-provided scribes and automated documentation platforms?	The use of artificial intelligence can pose significant risks including system malfunction leading to incorrect documentation without checking for accuracy. This risk can be mitigated through the implementation of clear policies and procedures and appropriate safeguards.	"General Medical Record Documentation Guidelines"-AI section
Is there a policy in place on the use of social media prohibiting staff from referencing patients and/or their care, responding to complaints, and/or defending negative social media postings?	Sharing of protected health information or acknowledgment of a patient's care on social media may lead to violations of patient privacy. A policy should be in place prohibiting staff from sharing any patient-related information, from responding to complaints, or to a negative posting. Consider assigning an individual or group to be responsible for reviewing social media posts. In some cases, it may be appropriate to follow up with the patient privately and off-line.	"Social Media Use"
MEDICATION MANAGEMENT		
Are medications, including sample drugs if used, checked monthly for expiration dates?	Expiration dates should be checked monthly when performing routine inventory of medications. Expired medications should be immediately removed from use and discarded according to recommended guidelines.	"Sample Medication Dispensing in the Outpatient Clinic"
If there is access to medication on the premises, do you have a drug diversion detection and prevention process, and does the interdisciplinary diversion team include pharmacy leadership when available?	Drug diversion in the healthcare setting can have devastating effects for patients, organizations, and healthcare workers. Diversion detection and prevention programs contain many components to successfully mitigate the risk, such as interdisciplinary teams, policy development, staff education, surveillance strategies, and investigation processes. Pharmacy involvement improves diversion detection reliability.	"Drug Diversion Prevention"
Is there a process in place requiring a provider to disclose to the patient when a medication is prescribed for off-label use?	Off-label prescribing is a common practice in medicine. Disclosing to the patient off-label use of medication aligns with a shared decision-making process. Patient understanding of rationale for use of an off-label medication, and subsequent	"Position Statement: Off-Label Medication"

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	agreement, will support the decision and assist in the defense should an unexpected adverse event occur.	
If prescribing controlled substances, are clinical practice guidelines in place regarding use of the Prescription Drug Monitoring Program (PDMP) database prior to ordering a controlled substance for patients?	PDMPs can help identify patients who may be misusing prescription opioids or other prescription drugs and who may be at risk for overdose. It allows providers to access crucial information, look for duplicate prescribing, drug interactions, and other potential concerns, while making sure patients have access to safe, effective care management.	
If your providers prescribe GLP-1 medications, do they limit patient selection to individuals who meet FDA-approved indications (e.g., Type 2 DM, BMI greater than or equal to 30, or BMI = 27 with at least one weight-related comorbidity)?	Limiting patient selection for GLP-1 medications to individuals who meet FDA approved indications helps ensure prescribing practices are evidence based, clinically appropriate, and compliant with regulatory standards. Prescribing these medications outside approved indications may expose patients to unnecessary risks.	"GLP-1 Considerations"
OPERATIONS		
Is there a process to follow when a near-miss or incident occurs?	Establishing an incident reporting system is an important safety measure. All staff should receive training on incident reporting to include the circumstances in which reporting is warranted. Identification and reporting of incidents and near misses can direct efforts to avoid similar events from re-occurring.	
Are trends analyzed using available information from patient complaint data, incident reports, and/or patient experience survey results?	Information acquired from patient complaints, incident reporting, and patient surveys should be reviewed and analyzed for trends. Resulting information can be used to improve care and enhance patient safety.	
Do you have a defined process in place for the inclusion of risk management when a serious	Risk management should be included when a serious patient grievance is made because such complaints can indicate potential quality of care, patient safety, or legal risk issues that exceed a complaint response. Risk management investigations	"Patient Complaint and Grievance Management"

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patient grievance or complaint is made?	ensure timely, structured investigations are completed in a confidential manner. Next steps, such as peer review, apology and disclosure, reporting requirements, and system improvements can be overseen by risk management.	
Is a defined procedure in place for handling medical emergencies in the practice setting, and are staff aware of their specific roles?	To minimize liability exposure, a defined procedure should be in place for appropriate handling of on-site medical emergencies. The procedure should identify designated roles for staff and who should be educated and aware of their specific responsibility during a patient and/or visitor medical emergency.	
Is the emergency kit locked and properly secured?	To support an immediate response to a life-threatening emergency the department/organization should have an emergency kit which is locked and secured to prevent unauthorized access.	
Is periodic testing and preventative maintenance of medical equipment performed on an established frequency?	Maintain, inspect, and test all inventoried medical equipment per the manufacturer's recommendations. Preventative maintenance allows for proactive performance of testing, repairs, and replacement of patient-care equipment, avoiding potential failures. This includes all medical equipment that is used for patient diagnosis and treatment, such as imaging equipment, defibrillators/AEDs, EKG machines, laboratory testing, etc.	
PATIENT SAFETY		
Is patient identity confirmed prior to providing a specific treatment or procedure by using a two-factor identification process?	One of the most common causes of medical errors is the incorrect identification of patients. To help ensure the right care for the right patient, it is recommended that in addition to the patient's name, an additional identifier such as date of birth, be used when drugs and/or other medical treatment is provided.	
Is there a policy guiding staff on the use of chaperones during patient visits?	Efforts to provide a comfortable and considerate atmosphere for the patient and the provider are part of respecting a patient's dignity. Having a chaperone present may also prevent misunderstandings between patient and provider. A policy	"Position Statement: Use of Chaperones"

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	should include staff guidance on circumstances under which a chaperone should be used, the use of a healthcare team member as the chaperone, and documentation requirements. In general, use a chaperone even when a patient's trusted companion is present.	
Are investigations associated with incidents and near misses performed?	A comprehensive investigation of reported incidents and near misses, along with a review of care, if indicated, may yield insights for change to improve the quality and safety of care. Trending of incidents provides a more systemic approach to identifying and addressing other opportunities within the organization.	"Managing an Adverse Event"
Is there a process in place for the safe dismissal of a patient who is inappropriate or noncompliant with care?	A process should be in place for a safe dismissal and transition of care when the patient-provider relationship is no longer therapeutic. Patient dismissal can lead to a claim of abandonment or discrimination if not done properly. Reasons can vary and may include behavior that is inappropriate and/or noncompliant with care. Safe dismissal often includes an initial written warning, serving as an opportunity for the patient to change behavior. Correspondence to the patient regarding a warning and/or dismissal should include delivery confirmation. For dismissals, include an effective date, interim care provisions, how to locate a list of physicians in the area, and a medical record copy request.	"Moving to Dismissal of Care", "Warning Before Patient Dismissal Sample Letter", "Dismissal of Care Sample Letter"
When necessary, do you utilize a behavior contract that lists expected behaviors, unacceptable behaviors, and consequences of non-adherence to the contract?	Listing expected behaviors helps the patient understand what is required to support their treatment plan. Listing unacceptable behaviors defines safe and respectful boundaries for both patient and staff and reduces the risk of misunderstanding. Consequences of non-adherence ensure the contract is enforceable.	"Outpatient Agreement for Safe and Acceptable Behaviors Sample Form"
Is there a process in place to communicate to affected patients about medications, medical implants, and/or equipment recalls?	It is important to have a mechanism in place to readily identify patients who may be subject to a recall. As manufacturers or suppliers notify providers of recalls, affected patients should be informed. This should prevent or reduce the impact of the recall on the patient's health. The notification should be documented,	"Documentation for Risk Mitigation During a Medication Shortage, Specialty Shortage, and Equipment Recall"

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	and the medical record should reflect any subsequent change to the patient's treatment plan as a result.	
STAFF COMPETENCY		
Do all healthcare staff, including all physicians and advanced practice practitioners, maintain current Basic Life Support certification?	It is recommended that all practitioners maintain BLS certification. This will help all staff to remain competent in current resuscitation protocols both for inpatient and outpatient services, as well as improve team communications. Maintain a copy of the current certification in the employee/practitioner's employee/credential file.	"The Need for Current BLS Certification Among Healthcare Providers"
Do position descriptions for unlicensed assistive personnel outline the supervisory responsibility of the licensed health-care professional?	State law may allow a licensed health-care provider to delegate certain patient-care activities. Although these activities are delegated, it remains the responsibility of the provider to supervise this delegation, so an appropriate standard of care is maintained.	
When sensitive exams are conducted, is the chaperone a healthcare professional who has documented competency training on file?	A proper chaperone is a trained healthcare professional who serves as an observer and a witness for a patient and clinician during a sensitive exam or procedure. Their presence can help reduce the risk of sexual misconduct and also reassure a patient about the professional context of the examination, enhancing the patient's safety, security, and dignity.	"Chaperone for Sensitive Medical Exams Training and Competency Sample Checklist"
Is applicant licensure, certification, or registration verified at the time of hiring?	Verification of licensure, certification, or registration is the responsibility of the organization. Actively licensed, certified, or registered staff minimize organizational liability by ensuring that staff meet the essential qualifications of the job.	"Hiring and Onboarding Process Guidance"
Is current licensure, certification, or registration verified annually?	While the responsibility for maintaining a current license, certification, or registration lies with the individual, the organization is responsible for ensuring that the individual complies. Absence of a current license, certification, or registration may result in prohibiting the healthcare professional from functioning in their current capacity until compliant.	"Hiring and Onboarding Process Guidance"

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Is training conducted and documented for newly hired employees and annually for current staff, on recommended/required educational topics?	The organization should determine what training is essential for safe and efficient practice, to reduce risks, and to comply with regulatory and/or accreditation requirements. Documentation of participation in education and training activities should be maintained. It is recommended that all employees be trained upon hiring and annually in the following areas: cultural and age specific competency, safe use of patient care equipment, incident reporting, handling patient complaints, harassment/sexual misconduct in the workplace, workplace violence/de-escalation training, confidentiality of PHI and organizational proprietary information, child, domestic, elder and alleged sexual abuse and neglect.	
CONDITIONAL CATEGORIES OF RISK		
Does the organization have guidelines in place identifying criteria and/or diagnoses that require patient referral to a physician from an APP?	The scope of practice of the Advanced Practice Professional (APP) may necessitate a patient referral to a physician. Therefore, it is important that the organization provide clear guidance on patient conditions that warrant elevating care to a physician. The guidance should include specific criteria and/or diagnoses.	"Advanced Practice Providers on the Care Team"
Is a process in place for over-reads of diagnostic imaging by a radiologist?	A process should be in place for the onsite interpreting provider to request an over-read by a radiologist. In addition to this select request for radiology consultation, the practice should consider routinely sending a blinded random sampling of images taken onsite for over-reads by a radiologist. This should be part of a quality improvement initiative.	
Are patients advised on the signs that should be immediately reported to the provider during the pregnancy?	Pregnant patients are at risk of developing pregnancy-related complications. Therefore, the patient should be educated on signs that warrant immediate notification to the provider and are indicative of potential risk to the patient and neonate.	
Are all providers trained in fetal heart monitoring and/or maintain competency on a regular basis?	Obstetric liability can involve allegations of failure to properly interpret or read fetal heart tracings. Therefore, providers should be trained in fetal heart monitoring. Ongoing competency should be maintained. The frequency of training may be	"Position Statement: Fetal Monitoring"

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	determined by the practice, according to best practice recommendations.	
If treating patients with chronic non-cancer pain, is there a policy and procedure in place for management of opioid prescribing?	A policy and procedure should be in place for the prescribing of opioids when treating chronic non-cancer-pain patients. The policy and procedure should align with current state and federal standards. This can contribute to safe and appropriate medication management to minimize the risk of drug dependency.	"Clinical Practice Guideline for Prescribing Opioids for Pain"
If sample medications are accepted from a pharmaceutical representative, is inventory tracking maintained, including drugs received and drugs dispensed to patients?	Providing medication samples in the clinic setting has inherent risks to patient safety. A log (manual or electronic) should be maintained of all sample medications as they are received and dispensed. When tracking medications that are dispensed, include patient name or medical record number, the name of the medication, lot number, quantity, and expiration date. All dispensed sample medications should be signed out in this log as well as documented in the patient's medical record.	"Sample Medication in the Outpatient Clinic"
Is a preoperative evaluation completed and documented to determine the patient's appropriateness for an office-based procedure?	A pre-operative evaluation should be completed. The physician should select patients for office-based procedures using the ASA Physical Status Classification System. Patients with an ASA greater than II should undergo the procedure in an accredited surgical center.	"Nonoperating Room Anesthesia (NORA)"
Is universal protocol used for identifying the correct patient and procedure site?	According to Universal Protocol guidelines, staff should correctly identify the patient and procedure site prior to the procedure. It is recommended that this occur and be documented with every office-based procedure.	
Are monitored-anesthesia patients attended by two qualified healthcare team members who are present at the time of induction?	A minimum of two trained healthcare team members should be available: one to assist the physician, and one to monitor and support the patient. It is recommended that at least one team member be trained in Advanced Cardiovascular Life Support, intravenous access, management of airway complications, and the use of pharmacologic antagonists.	"Nonoperating Room Anesthesia (NORA)"

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Is a plan in place for transferring patients to higher level of care, if needed?	The facility should have a written protocol in place for the safe and timely transfer of patients. There should be a prespecified alternate care facility when extended treatment or emergency services are needed to protect the health or well-being of the patient.	
Does the practice have written guidance outlining common conditions eligible for telehealth visits?	Telehealth can provide care to patients remotely; however, it may not be appropriate in every situation. Written guidance should be in place, outlining conditions or visit types that are appropriate for the specific practice and specialty. In addition, providers should use clinical judgment in determining the appropriateness of telehealth, based on these developed guidelines and the specific conditions of the individual patient.	"Telemedicine: Frequently Asked Questions"
Is a telehealth-specific informed-consent document required to be signed by the patient prior to the initial telehealth visit?	Consent to treat should be obtained from the patient prior to the initial telehealth visit. It is recommended that an informed consent document be implemented that outlines patient expectations and the unique characteristics of the telehealth experience. Since the same standard of care applies to a telehealth visit and an onsite visit, providers should make certain the informed consent process occurs when using technology as a means of treatment.	"Telehealth Informed Consent for Patient at Home"