MIEC
6250 Claremont Avenue
Oakland, CA 94618-1324

800.227.4527 **toll free**
510.654.4634 **fax**

miec.com

Claims Prevention Self-Assessment

WELCOME

Thank you for downloading the *Claims Prevention Self-Assessment*. This assessment will assist you in critically reviewing your practice systems, record-keeping practices, general charting habits, and electronic communication with patients.

To complete the self-assessment, review each section below and answer each question. After each section, you will be provided with a score based on your responses. The sections are as follows:

1. Practice Systems *(Questions 1-11)*
2. Medical Records Review *(Questions 12-42)*
3. General Charting Habits *(Questions 43-52)*
4. Electronic Communication with Patients *(Questions 53-59)*

1. PRACTICE SYSTEMS — QUESTIONS 1-11

Failure to develop and utilize office systems to track diagnostic tests, referrals to specialists, missed appointments and telephone communication between healthcare providers and patients have proven to significantly contribute to lawsuits in which the patients (plaintiffs) allege failure to diagnose a medical condition or injury.

1. Standardized system for tracking significant lab or X-ray tests ordered? ☐ Yes ☐ No

   Recommendation: Failure to diagnose or delay in diagnosis claims result when a medical practice does not have a system in place to ensure that ordered diagnostic tests are completed as ordered and results returned. Patients fail to have diagnostic tests done. Results are not returned to the ordering physician in a timely manner. With the assistance of your practice management system and medical staff, develop a method with which you can track all significant lab or X-ray tests that you ordered.

2. Charts include evidence of patient notification of diagnostic test results? ☐ Yes ☐ No

   Recommendation: Memorialize your efforts to contact patients with their test results. When applicable, document the specific advice, explanation, or instructions that are given. When staff members call on your behalf, ensure that they note that the information and/or advice came from you (i.e., “Per Dr. XX, advised patient…”). If you or your staff cannot reach the patient to convey the results, memorialize your efforts to do so.

3. Consistent system for notifying patients of POSITIVE diagnostic test results? ☐ Yes ☐ No

   Recommendation: Consider the following options for communicating with patients:
   - As a failsafe, ask patients to call for the results within a week after having lab tests or X-rays completed. Document the phone calls.
   - A healthcare provider calls patients to discuss the results. Document advice given and plan for treatment, follow-up office visit, change in medications, etc.
   - Ask staff to call and schedule a follow-up visit with patients to review the results.

4. Consistent system for notifying patients of NEGATIVE diagnostic test results? ☐ Yes ☐ No

   Recommendation: Consider the following options for communicating with patients:
   - As a failsafe, ask patients to call for the results within a week after having lab tests or X-rays completed. Document the phone calls or
   - Ask staff to relay negative test results to the patients and document their efforts to contact patients.
   - Send the test results in writing to patients.

5. Chart include evidence of physician review of lab, X-ray, and consultation reports ? ☐ Yes ☐ No

   Recommendation:
   - Initial the diagnostic information or write notes on the reports as evidence that you reviewed and considered the information.
   - Prohibit your staff from filing incoming reports without evidence of your review. In an EMR, have your staff task the results to you for review and sign-off.
   - Establish a time frame within which the results must be reviewed upon receipt (e.g., 24 – 48 hours).

6. Consistent system for follow up on referrals? ☐ Yes ☐ No

Recommendation:

Referring physician:

- Calendar when you expect to receive a response.
- If no response, call the patient to determine if he/she visited the consultant. If no, remind the patient of the need to visit specialist (document the reminder given and notify the requesting consultant). If yes, call consultant for report (note request in chart).
- If the response is received in writing, ask the staff to forward the report to you for review.
- If the response was received telephonically, ensure that your staff documents the information from the consultant and forwards it to you, including: the date, time and name of caller, and contents of the message. Request that the caller sends a written response to the requesting physician summarizing the consultation.

Consulting physician:

- It is essential that you communicate with referring physicians. A written and timely report that includes your assessment, advice, and treatment plan will: (A) maximize the value of the consultation; (B) help the referring physician treat the patient optimally; (C) minimize the potential for contradictory and incompatible care; and (D) contribute to complete documentation of the patient's care.

7. Policy for chaperones to be available during sensitive exams? ☐ Yes ☐ No

Recommendation: According to the American Medical Association's Opinion 8.21, "...A policy that patients are free to make a request for a chaperone should be established in each health care setting. This policy should be communicated to patients, either by means of a well-displayed notice or preferably through a conversation initiated by the intake nurse or the physician. The request by a patient to have a chaperone should be honored.

An authorized health professional should serve as a chaperone whenever possible. In their practices, physicians should establish clear expectations about respecting patient privacy and confidentiality to which chaperones must adhere. If a chaperone is to be provided, a separate opportunity for private conversation between the patient and the physician should be allowed. The physician should keep inquiries and history-taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination. (I, IV)"

8. Policy to manage patient complaints? ☐ Yes ☐ No

Recommendation: Studies show that patients' satisfaction with their healthcare is adversely effected, even to the point of considering litigation, when they are not offered a timely or credible explanation of unexpected complications, or answers to questions about their own or a relative's treatment. The leading reasons for patient complaints include: delayed receipt of test results; inaccessibility to healthcare (e.g., long waits for an appointment); lengthy waits to be seen by their healthcare provider; staff rudeness or a doctor's poor "bedside manner," and billing errors. Anticipating problems and responding promptly to complaints can improve patient satisfaction and prevent an unhappy patient from hiring an attorney or threatening to sue.

Define who will manage patient complaints:

- The Medical Director (or physician-owner) should respond to complaints about clinicians;
- The Practice Manager should address patient complaints about staff, scheduling issues, confidentiality, disruptive patients; and,
- The Billing Manager should respond to billing complaints.

We recommend that you implement a Patient Satisfaction Survey in your practice. Monitor the responses and implement changes in response to patient feedback.

9. Policy to manage in-office emergencies? ☐ Yes ☐ No

Recommendation: When managing emergencies in your practice, consider the following:

- Establish a 911 policy.
- Contract with a local hospital for admission of emergent patients.
- Define duties during the "Code" (e.g., who runs the code, who stabilizes the patient, who calls 911, who documents the event)
- If you choose to have a crash cart on site, maintain the crash cart appropriately.
- If you choose to have an AED on site, maintain it appropriately.
- Train all clinicians and staff on the emergency policy.
- Establish a timeline to run semi-annual/annual emergency drills.

The key to any emergency policy is training of the staff and maintaining skills to ensure a Code is run appropriately.

10. Confidentiality and HIPAA policies and procedures are in place? ☐ Yes ☐ No

Recommendation: To safeguard protected health information (PHI), ensure compliance with the following:

- Be familiar with state and federal laws affecting confidentiality and privacy of medical information.
- Be up-to-date with the HIPAA Omnibus Rule. Privacy and security measures include, but are not limited to:
    a. HIPAA privacy policy is in place.

b. Notice of Privacy Practices for Protected Health Information is current including your obligation to advise patients of a data breach.
c. Business Associates (BA) have received and signed an up-to-date agreement advising them of their responsibilities as BAs.
d. You have conducted a risk analysis of your practice as is required by the HIPAA Security Rule.
e. Staff has been HIPAA trained including breach notification requirements; training is ongoing as new issues arise in the practice.
f. Staff has been trained how to maintain patient confidentiality throughout the office.

11. Policy to manage the use of electronic communication with patients? ☐Yes ☐No

Recommendation: MIEC is mindful that electronic communication between patients and healthcare providers is increasingly a component of healthcare today. As much as we appreciate your efforts to accommodate patients in their desire to communicate with you via email and text and/or your desire to communicate information on a website, via email, or other social media such as Facebook or Instagram, MIEC suggests that you consider your liability as you engage in these activities.

Total number of "Yes" responses for questions 1-11? _____

Scoring: Excellent = 8-11 "Yes" responses
Good = 5-7 "Yes" responses
Needs Improvement = 1-4 "Yes responses

2. MEDICAL RECORDS REVIEW QUESTIONS 12-42

All experts agree that the safety of patients, the outcome of litigation, and the promptness of reimbursement depend upon legible, complete, timely, and accurate medical records. However, our experience in working on thousands of medical malpractice cases has convinced us that one of the most common reasons a medically defensible case is lost at trial or must be settled is that the medical record is incomplete or inadequate.

12. SOAP (or similar) format? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Medical consultants and legal counsel agree that the SOAP note (or a similar format) prompts physicians to include details to support optimal patient care and safety.

13. Patient health questionnaires are initialed as evidence of review? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Initial the questionnaires or write notes in the margins as evidence that you reviewed and considered the information. An alternative: routinely summarize the information in your progress notes.

14. Progress notes accurately reflect the details of office visits? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Some EMRs have the capability to automatically generate a clinic note that replicates the previous office visit note, or portions thereof. Physicians delete details that do not pertain to the current visit, commonly called "documentation by exclusion." The note becomes suspect when it includes identical levels of detail as the previous office note, an initial consultation note or annual History and Physical report. Avoid "cookie cutter" chart notes by ensuring the documentation accurately reflects the care provided during the visit.

15. Reasons for visit/complaints? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Begin each progress note with information about the reason for a patient's office visit. The absence of this data handicaps the defense against allegations that the doctor failed to diagnose a problem the patient reported. Use quotes to delineate patients' own words to describe their medical complaint.

16. Allergies or "NKDA"? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: It is essential to chart allergy (or NKDA) information. Document allergies (or NKDA) in a consistent location within each chart (e.g., medication list, EMR face sheet; progress notes, "Problem List") in order to avoid overlooked allergies and medication-related errors. "NKDA" is evidence that you asked and the patient denied allergies.

17. Current drugs patient is taking, including CAM, OTC, and "recreational" drugs? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: To safely prescribe medications, ask patients about medications other doctors have prescribed since the previous visit, over-the-counter (OTC) drugs, complementary and alternative supplements (CAM), and "recreational" drug use; document the information completely.

18. Other physicians the patient sees? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Document the names of other treating physicians and note the conditions and/or medications they are managing.

19. History of present illness (HPI) is detailed? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Professional negligence claims frequently stem from the healthcare provider's failure to take and document a detailed medical history. Progress notes should include the onset and duration of the patient's reported condition. Past medical, surgical, family and social histories should be consistently reviewed and documented.

20. Family members or friends who accompany patients to visits? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: It is prudent to note that another person is present during a patient's office visit and to document the individual's participation in the discussion, if any. Include the person's name and relationship to the patient in your note. Should your discussion with the patient come into question at a later time (e.g., during a medical malpractice lawsuit), your attorney would be able to contact the person who witnessed the conversation.

21. Interpreters who translate during an office visit? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Document the presence of an interpreter, his/her name and relationship to the patient. This is evidence of your efforts to communicate clearly with your patient. Also, if possible, make sure that the interpreter is proficient in English, and avoid using a child to translate.

22. Lab, X-ray, and consultation reports are initialed or summarized in the progress notes as evidence of review? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Initial the diagnostic information or write notes on the reports as evidence that you reviewed and considered the information. Prohibit your staff from scanning the reports into the EMR or filing them in your paper charts without evidence of your review. If reports are received digitally from the laboratory, electronically sign the reports as evidence of review. Use the information to generate periodic aggregate reports to help you manage critical lab values. It is also a prudent practice to review results in your progress notes as evidence that you considered the information as part of your care and treatment of your patients.

23. Reasons diagnostic tests ordered or deferred are documented? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Ambiguous or absent information about ordered tests leaves room for guesswork about your thought process. Include enough information that another physician will be able to understand the motivation for ordered tests.

24. *Surgical specialties:* Pre-op diagnostic tests and medical clearance reports (e.g., lab work, chest X-ray, EKG) are initialed as evidence of review? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Initial or sign the reports as evidence that you reviewed and considered the information to clear the patient for surgery.

25. Pertinent positive and negative exam results? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Negative test results are often as significant as positive. Be specific about the importance of your clinical findings.

26. Impression or diagnosis; rule-out list? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Documentation of your medical decision making and judgment reduces the potential for misunderstanding your subsequent actions, particularly when there is justification for deviation from accepted or customary care. Indicate "why" and "how" differential diagnoses are considered and/or ruled-out.

27. Prescribed medications are documented completely in progress notes or on a Medication Control Record? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: When documenting medications, note the indications, name of the medicine, dose, amount, instructions and number of refills you authorize. Utilize the EMR's technology to e-prescribe and manage medications over time. Determine if the system alerts the provider to medication contraindications.

28. Consistent system to document medication refills, renewals, and changes. Notes include who authorized the order and initials of the staff who called the refill into the local pharmacy? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: When documenting medications, note the indications, name of the medicine, dose, amount, instructions and number of refills you authorize. Make certain that your staff's documentation clearly indicates that you authorized the medication renewal or new prescription. (For example: "per Dr. XX")

29. Progress notes of pain medication management clearly detail management of patient's pain? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: To best protect yourself and your patients, document details that adhere to your state medical board's Guidelines for Prescribing Controlled Substances for Pain. These include, but are not limited to: complete histories (e.g., personal, social, alcohol, smoking, drug use, family, physical, psychological), a pain scale, physical examination, assessment, and detailed treatment plan.

In addition to specific record-keeping:

- Be familiar with "black box" warnings for all controlled substances that you prescribe.
- Develop and adhere to risk reduction strategies, including: urine drug screens, regular face-to-face office visits to evaluate patients' response to opioids and risk of misuse, follow a pre-defined refill schedule (i.e., restricting refills of opioids prior to expiration of the previous prescription), and documentation that clearly provides evidence of your treatment plan and management thereof.
- Have patients sign a Medication Management Agreement.
- Consider seeking a pain management consultation for patients whose medication management becomes complex, or those who present with few clinical symptoms. Carefully document physical findings (or lack thereof) and refer such patients to a pain management specialist or a psychiatrist.

30. Treatment rendered in- office? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Document details of treatment rendered in the practice. Include location of injection sites, medication lot numbers, patients' responses to in-office treatment and any other significant observations.

31. Sufficiently-detailed **interim** progress notes that track patient's progress? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Document a detailed interim history to provide evidence of the patient's progress or lack thereof since the last visit. Include details about medication efficacy, decreased pain, increased activity, weight loss, etc. and more, to provide evidence of medical management.

32. Sufficiently-detailed **post-op** notes that track patient's progress? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Vague notes such as "doing well," feels better," or "no problems" are less helpful in retrospect than notes such as, "wound is clean," "patient reports substantially increased energy," and "afebrile, healed suture line." Note specific details to support your recommendations and/or further treatment.

33. Follow-up advice given to patients including future recommended treatments? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Specific short- and long-term treatment plans are evidence of care management. Include discussions with patients about recommended future treatment. Pass responsibility to patients by documenting the specific advice you give patients for follow-up, disease-management, diet, exercise, medication use, etc., and patients' response to that advice.

34. Informed consent discussions? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: You decrease your liability risks when you clearly document in the progress notes that: (A) you informed the patient of the material risks, benefits, and alternatives of your recommendation; (B) you answered the patient's questions; and, (C) the patient chose to proceed. This documentation refutes patients' claims that they would have refused the treatment had they understood the risks or the alternatives to treatment. Avoid documenting informed consent in the operative or procedure reports, which are dictated after the surgery or procedure. If problems occur, notes about pre-op discussions of complications or potentially adverse outcomes in these after-the-fact reports appear self-serving and may lack credibility in court.

35. Informed refusal discussions? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: The **"informed refusal"** doctrine says that competent adult patients have a right to refuse treatment, even if they could suffer severe consequences as a result. You may be obligated to tell your patients the **material or significant risks of refusing a recommended test or procedure.** You protect yourself when you document the content of an informed refusal discussion and patient understanding, whether or not required by state law.

36. Specific referral notes? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: You decrease your liability risks and promote continuity of care when you clearly chart referrals to specialists including adequate clinical information and what you anticipate from the consultant. Telling patients why you are referring them and confirming their cooperation transfers responsibility to them for following through with a specialist.

37. Documentation of patient non-compliance? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: You protect yourself from liability when you document a patient's failure to follow your advice. In defense of a lawsuit, it indicates that the patient may have contributed to his or her own injury.

38. Return visit date or timeframe to follow-up? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: When you tell patients to return within a specific time frame and document your instructions, you transfer responsibility for returning to the atients. It is difficult for patients to claim that your care was negligent if they failed to return as advised.

2. MEDICAL RECORDS REVIEW (continued) QUESTIONS 12-42

39. Oral and written patient education? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Document your education efforts in the medical record as evidence of your attempts to reduce injury, improve compliance, ensure realistic expectations, and enable patients to share in medical decisions. Many physicians specifically note patient understanding in the progress notes. Document that written medical information was dispensed. This dispels patients' claims that you failed to explain something that had the patient known, he/she would have made a different decision or behaved differently.

40. Return to work, school orders are specific, unambiguous? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: "Specific" means that your "return to ..." orders detail the patients' limitations on activities such as lifting, carrying, climbing, standing, walking, operating equipment, etc.

41. Electronic entries are finalized by e-signature and/or other means, in a timely manner.? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: All electronic entries, as with paper chart notes, should be generated contemporaneously to events, should clearly indicate who authored the note, and should be finalized/unalterable when the entry is completed, preferably the same date the entry was made. Office policies should specify a time frame within which the chart entry must be electronically signed and closed.

42. Oral and written patient education? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Document your education efforts in the medical record as evidence of your attempts to reduce injury, improve compliance, ensure realistic expectations, and enable patients to share in medical decisions. Many physicians specifically note patient understanding in the progress notes. Document that written medical information was dispensed. This dispels patients' claims that you failed to explain something that had the patient known, he/she would have made a different decision or behaved differently.

Total number of "Yes" responses for questions 12-42? _____

Scoring: Excellent = 22-30 "Yes" responses
Good = 16-21 "Yes" responses
Needs Improvement = 1-15 "Yes responses

3. GENERAL CHARTING HABITS QUESTIONS 43-52

Some general chart habits and their management will assist you in the care of your patients and strengthen the quality of your charts as medical-legal documents.

43. Charts are well organized? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Ensure that all chart contents are attached. Leaving pages loose in your charts is an easy way to lose or misplace important patient information. Filing information in chronological order and using section dividers decreases the likelihood that important information will be lost or overlooked, or that confidential information will be improperly released. When selecting an EMR, consider how intuitive the system is. Will managing the data be cumbersome, exposing you to the possibility that information will be overlooked? Some EMRs allow you to access data from at least three different entry points. Consider the importance of easy accessibility.

44. Handwriting is legible? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: If your handwriting is difficult to read, consider other options: hire a scribe; print; dictate your progress notes; or invest in an EMR. All handwritten documents scanned into the EMR should be legible. Require your staff to write legibly. Explain that illegible handwriting could cause patient injury and increase your liability.

45. Chart entries are dated and signed or initialed? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: All entries should clearly indicate who authored the note and the date of the entry. Entries should be signed or initialed (either electronically or handwritten if scanned into the EMR). Initialed/signed entries add credibility to the chart notes and limit the number of people a plaintiff's attorney can depose about an entry—to find out who wrote it.

46. "Problem List" is up-to-date? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Consistently update your "Problem List." If the form is kept current, you can see at a glance: medication patterns, significant health events, chronic problems, and more. You can train medical assistants to update information as you receive it.

3. GENERAL CHARTING HABITS (continued) QUESTIONS 43-52

47. Post-it® notes, if present, are permanently attached? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Sticky notes are temporary and can easily be lost. Plus, they are too small! Documenting information directly into the chart is much safer. If you decide to use sticky notes, attach them to the chart with tape or staples, and include the patient's name and the complete date [mm/dd/yy].

48. Blanks on forms are filled in appropriately? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: A blank space on a form does not always signify a negative response. Plaintiffs' attorneys and jurors may regard blank spaces on an examination template as evidence that parts of the exam were not done. Fill in or void all spaces for information on forms. Ask office staff to review patient forms to ensure the forms are complete. Don't sign operative reports, discharge summaries, or other transcription before filling in blanks.

49. Errors are corrected appropriately? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Changes to the chart that obscure both the original entry and correction may cause information to be misinterpreted and result in patient injury. Unexplained changes could look like fraudulent alterations. Draw a single line through the error, date and initial it, and write the correction adjacent to the mistake.

50. Consistent system for documenting significant phone calls? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Significant telephone calls are those in which information regarding a change in a patient's condition (e.g., new symptoms, reaction to medication, etc.) is received or relayed, medical decisions are made, and/or medical advice is given. Information exchanged via these telephonic encounters is vital to the ongoing care and treatment of the patient. Ensure documentation of this significant communication. Chart entries should include the patient's name, the date of the call, details of the discussion, advice given and by whom, action taken, decisions made and the author's initials. Ensure that staff attributes advice given on your behalf to you (i.e., "Per Dr XX").

51. Significant phone calls taken while on-call are documented completely? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Many physicians have lost substantial damages cases related directly to undocumented after-hours phone calls. Protect yourself from liability by documenting: the history the patient communicated; the advice you gave; and the patient's response. Note the time of the phone call, and send a copy of the communication to your colleague. **Remember:** When a patient refuses your recommended treatment, such as, "Go to the ED," document the details of the discussion, the risks reviewed, and the patient's response.

52. Consistent system to document failed, canceled, rescheduled appointments? ☐Yes ☐No ☐Inconsistent ☐N/A

Recommendation: Patients who frequently miss or cancel appointments may place themselves at risk; some may try to blame you for injuries caused by their own negligence. Many electronic systems have a practice management component used to schedule appointments, document failed appointments and more. We recommend that failed appointment (e.g. "no shows"), cancellations, and rescheduled visits be documented in the medical record in addition to the practice management/ scheduling portion of the program. Failed appointments documented in the charts help you to track patients who may be non-compliant. A plaintiff's attorney who obtains a pre litigation copy of the medical chart is less likely to take the case of a patient who obviously failed to return for further care.

Total number of "Yes" responses for questions 43-52? _____

Scoring: Excellent = 6-10 "Yes" responses
Good = 4-5 "Yes" responses
Needs Improvement = 1-3 "Yes responses

4. ELECTRONIC COMMUNICATION WITH PATIENTS QUESTIONS 53-59

As electronic communication becomes more prevalent in the physician/patient relationship, consider how you use various platforms to communicate protected health information while protecting your practice from liability.

53. A secured portal is used to communicate with patients? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: To ensure that protected health information is appropriately protected when communicating electronically with patients, incorporate a secure portal into your practice. We recommend the following to help reduce your risk:

- Allow patients to use the portal to make appointments, request prescription refills, ask simple questions, and build their personal health record.
- Use the portal to send appointment reminders, report negative test results, answer simple medical questions.
- Avoid communicating about complicated medical issues or significant positive test results via the secured messaging system. This type of information should be discussed during a follow up office visit or perhaps "live" over the phone.
- Consider who will respond to patients' emails and timeliness of the communication.
- Ensure that communication (both email and text messaging) between you and patients or you and your staff can be saved to the EMR.

4. ELECTRONIC COMMUNICATION WITH PATIENTS (continued) QUESTIONS 53-59

54. Patients are asked to sign Digital Communication Agreement? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Consider having patients sign an agreement that clearly defines how digital communication will be used in the practice. A sample agreement is available from MIEC's Patient Safety Risk Management Department.

55. The practice uses a website to introduce patients to the practice and its policies? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: When developing a website for your practice, we recommend the following:

- Introduce the healthcare providers and staff to patients.
- Outline policies and procedures about cancelled appointments, medication refills, after hour questions, co-pays, what to do in case of an emergency, and more.
- If you choose to use the site to answer medical questions, make certain to include a disclaimer that: your responses are general in nature; a physician-patient relationship is not established via the online correspondence; and the inquirer should make an appointment with his/her personal healthcare provider.
- Include a disclaimer about the links on your website.
- Hire a webmaster to manage your website to keep it updated and to ensure accuracy of information.

56. The practice uses social networking to update patients? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Although social media is a common means to communicate and interact, we recommend that you ensure:

- Facebook or other platforms are used to educate or inform patients (e.g., availability of flu vaccines; holiday business hours; introduction of a new physician or staff member to the practice; upcoming health fairs; changes in specialty; and how to manage illness).
- Limit the use social media to communicate one-on-one with patients.
- Do not allow patients to "friend" your Facebook page.
- Do not "friend" your patients.
- Train staff on how social media is to be used in the practice and how to avoid HIPAA confidentiality violations.

57. The practice has a policy for responding to unfavorable reviews on social media sites (e.g., Yelp!)? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Keeping the physician-patient relationship healthy continues to be a challenge for physicians. Unfortunately patients are using social media sites more frequently to complain about the physician-patient encounter. We recommend that you have a policy in place defining how to respond to those postings (if at all). It is important for you to know:

- Any response to a post should be general in nature. You cannot confirm that messages were posted by patients without their permission.
- You have little recourse for removing the post from the site. Even if you contact the site, most requests for redaction of postings are denied.
- Encourage unhappy patients to contact you directly to discuss their complaints and how you might address them.

58. Staff sign a Social Media Agreement? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Consider having staff signs an agreement that clearly defines how social media will be used in the practice. A sample agreement is available from MIEC's Patient Safety Risk Management Department.

59. Patients sign a Social Media Agreement? ☐ Yes ☐ No ☐ Inconsistent ☐ N/A

Recommendation: Consider having patients sign an agreement that clearly defines how you and your patients will be use social media to communicate. A sample agreement is available from MIEC's Patient Safety Risk Management Department.

Total number of "Yes" responses for questions 53-59? _____

Scoring: Excellent = 6-7 "Yes" responses
Good = 4-5 "Yes" responses
Needs Improvement = 1-3 "Yes responses

Practice Name: _____ Survey completion date: _____